# Services de Santé de Qualité pour Haiti (SSQH) Central and South
# Contract No. AID-521-0-13-00011

## FY 2016
## Annual Report: October 1, 2015 – September 30, 2016

Photo credit: Frederick C. Alexis

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# ACRONYMS

| | |
|---|---|
| **ANC** | Antenatal care |
| **ART** | Antiretroviral treatment |
| **ASCP** | Agent de Santé Communautaire Polyvalent |
| **BEST** | Bien et al Santé Timoun Project |
| **CDS** | Centres pour le Développement et la Santé |
| **CHW** | Community health worker |
| **CP** | Child protection |
| **CQI** | Continuous quality improvement |
| **DDS** | Direction Départementale Sanitaire |
| **DHIS2** | District Health Information System 2 |
| **DPO** | Departmental program officer |
| **DQA** | Data quality assessment |
| **ER** | Expected result |
| **FP** | Family planning |
| **FOSREF** | Fondation pour la Santé Reproductrice et de l'Education Familiale |
| **GBV** | Gender-based violence |
| **HTC** | HIV testing and counseling |
| **HMIS** | Health management information system |
| **LMG** | Leadership, Management, and Governance project |
| **LMS** | Leadership, Management, and Sustainability project |
| **LTFU** | Lost-to-follow-up |
| **M&E** | Monitoring and evaluation |
| **MESI** | Monitoring, Evaluation and Surveillance Interface |
| **MNH** | Maternal and newborn health |
| **MCSP** | Maternal Child Survival Project |
| **MSPP** | Ministère de la Santé Publique et de la Population |
| **NGO** | Non-governmental organization |
| **OVC** | Orphans and vulnerable children |
| **PEPFAR** | President's Emergency Plan for AIDS Relief |
| **PIH** | Partners in Health |
| **PLHIV** | People living with HIV |
| **PMP** | Performance monitoring plan |
| **PMTCT** | Prevention of mother-to-child transmission |
| **RBF** | Results-based financing |
| **RH** | Reproductive health |
| **SCMS** | Supply Chain Management System project |
| **SDSH II** | Santé pour le Développement et la Stabilité d'Haïti II project |
| **SISNU** | Système Information Sanitaire National Unique |
| **SSQH/SSQH-CS** | Services de Santé de Qualité pour Haïti Central-South project |
| **TA** | Technical assistance |
| **TB** | Tuberculosis |
| **TdB** | Tableau de bord |
| **UADS** | Unité d'Appui au Direction Sanitaire |
| **UAS** | Unités d'Arrondissement de Santé |
| **UEP** | Unité d'Évaluation et de la Planification |
| **USAID** | United States Agency for International Development |
| **WASH** | Water, sanitation, and hygiene |
| **ZC** | Zone ciblées |

# EXECUTIVE SUMMARY

SSQH is pleased to present its project year three (PY3) annual performance report. As its final year of implementation, PY3 focused on strengthening service delivery quality, improving coordination with MSPP and DDS partners, and smooth program transition. SSQH's scope changed effective April 2016 and entered early completion. As a result of this change, technical assistance and related field activities ended in March and comprehensive service continued through July 2016. Therefore, results presented reflect six months of full program implementation, and six months of scale back and transition.

Key elements SSQH employed to strengthen service quality include intensified support for HIV services and further strengthening of the referral network; roll out of refined quality improvement tools such as CQI, waste management, and RBF business plans; and material support for CHWs to better equip them as community providers. SSQH placed departmental program officers (DPO) and project vehicles at each of the DDS to improve activity coordination and strengthen relations between SSQH and the departments. Finally, SSQH coordinated with USAID, MSPP, and MCSP for seamless service delivery transition and program handover.

Overall, SSQH excelled in many of its service delivery indicators, most notably for HIV/AIDS. Other strong performances are noted in TB, MH, FP, and GBV domains. Selected highlights from the year are below:

**Success Highlights**

For **HIV/AIDS**, SSQH met or surpassed ER for 17 indicators for an overall achievement rate of 85%. Selected high performing indicators are: number of pregnant women with known HIV status; number of HIV+ people newly enrolled in clinical care; number of adults and children currently receiving ART; and percent of HIV+ people known to be alive and on treatment 12 months after initiation of ART. These achievements underscore SSQH's ability to find more HIV+ people, enroll them in care and treatment, and retain them in care. **TB** results were strong for case notification rate in new sputum smear positive pulmonary TB cases and percent of HIV-positive patients in HIV care treatment who started TB treatment.

**MCH** indicators saw successful results, with both the percent of births managed by a skilled birth attendant and the percent of postpartum/newborn visits within 3 days reaching ERs. The number of women reached by exclusive breastfeeding messages also performed well. For **FP/RH**, SSQH well surpassed its ER for the number of youth (aged 15 – 25) accessing RH services. **GBV/CP** indicators out-performed expectations, with related services and referrals reaching more people than any previous year. In total, a record **2,506,131** people received services provided by SSQH-supported facilities or CHWs during the year.

Despite these impressive gains, SSQH experienced challenges this year. In March, USAID moved SSQH to early closeout, reducing its scope to cease technical assistance and shift its budget to focus exclusively on service delivery for the second semester. This decision effectively reduced the impact SSQH could make on service delivery quality, use, and management the year. It furthermore compromised SSQH's support for the DDS, as the complete suspension of technical assistance halfway through the year eroded efforts to support the departments in providing comprehensive supervision visits to sites and conducting data use and management activities. Other performance was undermined with this decision: all training activities and community mobilization efforts in support of establishing emergency transportation systems ceased before results could be realized.

The second semester focused on managing early project completion and transitioning service delivery to MCSP. SSQH collaborated with the DDS, USAID, and MCSP to transfer knowledge, processes, and resources. Key participants for the project transition were the DPOs, who liaised between SSQH and the health departments and MSCP while coordinating activity implementation. MSCP will continue the use of these resources moving forward. SSQH participated in the MSCP-sponsored joint SSQH workshop in August, during which it presented its PY3 first semester results to partners. Finally, SSQH continued limited data management support through July, with SSQH officers conducting DQA visits at both facilities and departments.

# INTRODUCTION

The Services de Santé de Qualité pour Haiti- Central and South (SSQH-CS) project is a three-year health service delivery initiative in Haiti funded by the United States Agency for International Development (USAID). SSQH supports the Ministère de la Santé Publique et de la Population (MSPP) to improve the health status of the Haitian population. Led by Pathfinder International, the SSQH consortium includes Centres pour le Développement de la Santé (CDS); Deloitte Consulting, LLP ; Dimagi; the Fondation pour la Santé Reproductrice et de l'Education Familiale (FOSREF); GHESKIO ; and Partners In Health (PIH).

SSQH-CS has four objectives:

(1) Increase the utilization of the Ministère de la Santé Publique et de la Population's integrated package of services at the primary care and community levels (particularly in rural or isolated areas;
(2) Improve the functionality of the USG-supported health referral networks;
(3) Facilitate the sustainable delivery of quality health services through the institutionalization of key management practices at both the facility and community levels; and
(4) Strengthen departmental health authorities' capacity to manage and monitor service delivery.

SSQH-CS works in six of the ten departments in Haiti, including West, Center, South, South-East, Nippes, and Grand Anse, providing clinical and community-based services for the catchment area's nearly 2.65 million people (approximately 25% of the country's estimated 10.4 million population in 2015). Service delivery entails the provision of MSPP's Essential Package of Services, which includes services in HIV/AIDS (including clinical and psychosocial service support to Orphans and Vulnerable Children [OVC]); Tuberculosis (TB); Maternal and Child Health (MCH) (including Water, Sanitation and Hygiene [WASH], and Nutrition); and Family Planning (FP). In addition, SSQH supports Gender-Based violence (GBV) and Child Protection (CP) services at selected sites, as well as the provision of training and limited support for basic critical care (accident and emergency) for project sites within the Port-au-Prince and parts of the St. Marc USAID Development Corridors. A critical link between communities and facilities reinforced and supported by SSQH is the Agents de Santé Communautaires Polyvalents (ASCP), who provide first level services in MCH, FP, STI/HIV/AIDS, TB, and nutrition.

Key project strategies for reaching these objectives include (1) strengthen the technical knowledge, skills, and capacity of health care providers at facility and community levels; (2) train and mentor health care leadership in management practices; (3) establish and strengthen service networks extending from the household to hospitals; (4) assess and where feasible, refurbish physical infrastructures and supply equipment to facilities; (5) promote community involvement and mobilization; and (6) support implementation of the MSPP results-based financing (RBF) scheme.

In March 2016, USAID informed SSQH that it was to enter early project completion. As a result of this decision, SSQH suspended its technical assistance March 31 for all programmatic areas except M&E. Comprehensive services were funded through July 2016. Accordingly, annual results presented in this report reflect abridged efforts: some indicators present annual progress based upon October 2015 to March 2016 activities, while others (particularly service delivery indicators) present annualized results using nine months of data (October 2015 – June 2016).

This annual report covers the project year three (PY3) annual activities and results from 1 October 2015 to 30 September 2016. The report is divided into sections by objective (1-4); and management, monitoring, and administration. Performance tables for indicators and annual highlight boxes are

included throughout the report. The full PMP with data for indicators with annual reporting frequency is in Annex A.

**Figure 1: An ACSP in her community.**

# OBJECTIVE 1
## INCREASE THE UTILIZATION OF THE MSPP INTEGRATED PACKAGE OF SERVICES AT THE PRIMARY CARE AND COMMUNITY LEVELS

Annual Highlights

- ✓ **1,692** HIV-infected adults and children newly enrolled in clinical care and received at least one of the following: clinical assessment, CD4 count, or viral load
- ✓ **4,868** adults and children currently receiving ART
- ✓ **104,492** youth (aged 15-25) accessing reproductive health services
- ✓ **2,506,131** clients accessing services provided by project-supported facilities and CHWs

SSQH ensures the delivery of health services in USAID-supported networks and scales up access and use of MSPP's essential package of services at facility and community levels. The project supports the delivery of services at 80 sites and their surrounding communities. Grounded in the continuum of care from the community to facility level, the project brings essential services to the lowest possible levels while improving the quality of services along the continuum. Focused technical assistance targets the improvement of service quality and integration, and support for CHW broadens the delivery of services at community levels. Mobilization and support of community groups work to increase demand for and use of these improved services. Finally, the project acknowledges the efforts and good work carried out by the health sector personnel at the 80 participating service delivery sites, who play a pivotal role in the SSQH's performance.

*Due to SSQH entering early project completion, PY3 results are calculated using the October 2015 – June 2016 service data and multiplying them by a coefficient to determine the projected annual result. This is so that the projected annual results can be compared to the established annual targets, which was based upon 12 months of services.*


**Figure 2: SSQH-CS supported facilities [data source: SSQH-CS Site Database]**

## HIV/AIDS

| HIV/AIDS Indicator Performance Summary Table | |
|---|---|
| **Met 90-110% of Expected Result (N = 13)** | No. of pregnant women with known HIV status (HIV01): **42,383** or **106.6% ER achievement** |
| | % of pregnant women with known HIV status (HIV01a): **98.3%** or **103.2% ER achievement** |
| | % of HIV+ pregnant women who received antiretrovirals to reduce risk of MTCT (HIV03): **81.8%** or **109.4% ER achievement** |
| | % of HIV+ patients who were screened for TB in HIV care or treatment setting (HIV14): **92.0%** or **92.0% ER achievement** |
| | No. of adults and children newly enrolled on ART (HIV18): **1,601** or **99.0% ER achievement** |
| | No. of adults and children currently receiving ART (HIV19): **4,868** or **91.3% ER achievement** |
| | % of adults and children known to be alive and on treatment 12 months after initiation of ART (HIV20): **77.9%** or **92.0% ER achievement** |
| | No. of HIV+ adults and children receiving care and support services outside of the health facility (HIV20a): **5,058** or **92.6% ER achievement** |
| | % of registered new and relapsed TB cases with documented HIV status (HIV23): **95.4%**or **104.1% ER achievement** |
| | No. of active beneficiaries served by PEPFAR OVC programs for children and families affected by HIV (HIV26): **6,362** or **97.6% ER achievement** |
| | % of HIV service delivery points supported by PEPFAR that are providing integrated voluntary FP services (HIV27): **100%** or **100% ER achievement** |
| | No. of PEFAR-supported testing facilities with capacity to perform clinical laboratory tests (HIV29): **17** or **100% ER achievement** |
| | % of PLHIV in HIV clinical care who were screened for TB symptoms at the last clinical visit (HIV32): **90.4%** or **90.4% ER achievement** |
| **Exceeded Expected Result > 110% (N = 4)** | No. of individuals who received Testing and Counseling services for HIV (HIV10): **160,541** or **138.2% of ER achievement** |
| | % of HIV+ patients in HIV care treatment (pre-ART or ART) who started TB treatment (HIV15): **80.4%** or **>200% ER achievement** |
| | No. of HIV+ adults and children who received at least one during reporting period: clinical assessment, CD4 count, or viral load (HIV25): **7,719** or **117.9% ER achievement** |
| | No. of HIV-infected adults and children newly enrolled in clinical care during the reporting period and received at least one of the following: clinical assessment, CD4 count, or viral load (HIV29): **1,692** or **164.1% ER achievement** |
| **Below < 90% Expected Result (N = 3)** | No. of HIV+ adults and children receiving a minimum of one clinical service (HIV11): **7,583** or **48.1% ER achievement** |
| | % of infants born to HIV+ women that receive a virological HIV test within 12 months of birth (HIV16): **44.9%** or **49.9% ER achievement** |
| | % of HIV+ new and relapsed registered TB cases on ART during TB treatment (HIV23a): **60%** or **73.7% ER achievement** |

**Table 1: HIV/AIDS Indicator Summary Table**

Overview of HIV Indicator Results

HIV indicators performed very strongly for the year, with 85% (n=17) meeting or exceeding their annual expected results (ER). Under the first objective of the HIV strategy[1] – *to increase the identification of HIV+ patients* – SSQH met or exceeded annual targets for several indicators. Both the number of people tested and counseled (HTC_TST, n=160,541 or 138.2% ER achievement), and its subset indicator, the number of pregnant women with known HIV status (PMTCT_STAT, n=42,383 or 106.6% ER achievement) did well. These successes can be attributed in part to efforts to increase the availability of testing services at maternities (i.e. during off-hours) and index-case testing. Targeted testing for populations at elevated risks also yielded results: the percentage of new and relapsed TB cases with documented status (TB_STAT) was 95.4% or 104.1% ER achievement. However, systemic challenges tempered testing efforts to provide infants born to HIV+ women a virological HIV test within 12 months of birth (PMTCT_EID, 44.9% or 49.9% ER achievement). Delays during the first quarter resulted from the national lab not being able to process specimens and return results to facilities while it underwent system renovations. There was often a two-month lag between when specimens arrive for testing and when the results were returned, thereby affecting indicator performance.[2] Intensified coordination with CARIS foundation and selected sites (i.e. CSLB and CSNRR) to increase access to specimen transport support for diagnosis aimed to improve coverage.

Indicators measuring the HIV strategy's second objective – *to increase the number of new PLHIV enrolled in care and treatment services* – posted impressive gains. More HIV+ patients received clinical care services during the period, be they clinical assessments, determined eligibility for ART, initiation of ART for eligible patients, or other clinical services. The number of HIV-infected people newly enrolled in clinical care (CARE_NEW) significantly outperformed expectations (n=1,693 or 164.1% ER achievement), while the number of HIV+ people receiving clinical care services for the year (CARE_CURR) also performed strongly (n=7,719 or 117.9% ER achievement). SSQH made strides to ensure these patients received comprehensive care, as 90.4% of PLHIV in clinical care were screened for TB symptoms (TB_SCREEN) during the period. Other efforts to provide care and support to affected groups are noted in OVC data, with 6,362 active beneficiaries serviced (or 97.6% ER achievement) by OVC programs for children and families affected by HIV (OVC_SERV).

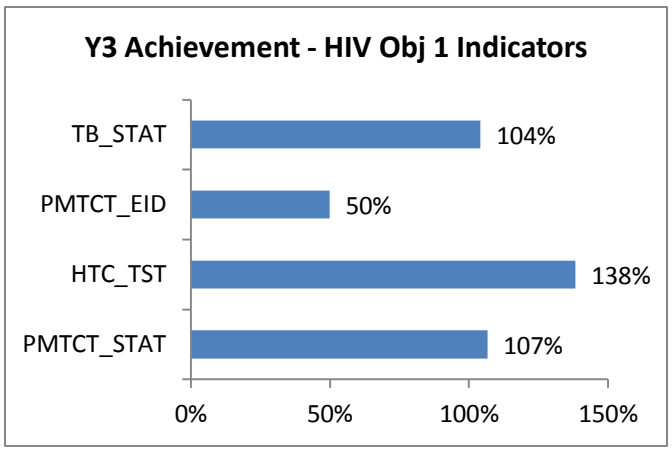


**Figure 3: Y3 Achievement for HIV objective 1 indicators.**

[1] In support of MSPP's goal of having 90% of people knowing their HIV status, 90% of HIV+ enrolled in care and treatment, and 90% of ART patients with suppressed viral load by 2020, and in line with the PEPFAR approach of saturation, SSQH revised its PY3 HIV strategy to focus services at 17 sites. This strategy establishes three categories for sites within the SSQH priority districts: aggressive intervention (for sites serving more than 300 PLHIV annually), saturate (for sites serving between 30-300 PLHIV), and maintain (sites serving fewer than 30 PLHIV). Technical approaches and activities vary per category and site, all of which look to increase the identification of HIV+ patients, increase the number of new PLHIV enrolled in care and treatment, improve PLHIV retention in care and treatment, and enhance ART adherence.

[2] Site-level register review presents a different reality: a project review of PMTCT and pediatric registers of patients aged six weeks to 12 months during the April 2015 to February 2016 period at 14 HIV sites showed 77.5% of exposed infants received a viral load test result (107/138), while 30 more specimens were at the national lab for evaluation at the time of the survey.

Many patients who were eligible for ART started treatment: the number of adults and children who were newly enrolled on ART (TX_NEW) was 1,601 (or 99.0% ER achievement), while its subset indicator, the percent of pregnant HIV+ women who received ART to reduce the risk of MTCT (PMTCT_ARV) was 81.8% (or 109.4% ER achievement). However, obstacles prevented selected groups of PLHIV from enrolling in treatment immediately. Challenges remain in successfully linking TB and ART programs, as evidenced by only a 60% or 73.7% ER achievement for enrolling co-infected patients in ART (TB_ART). This modest performance demonstrates the further need to improve program integration between TB treatment and ART services.

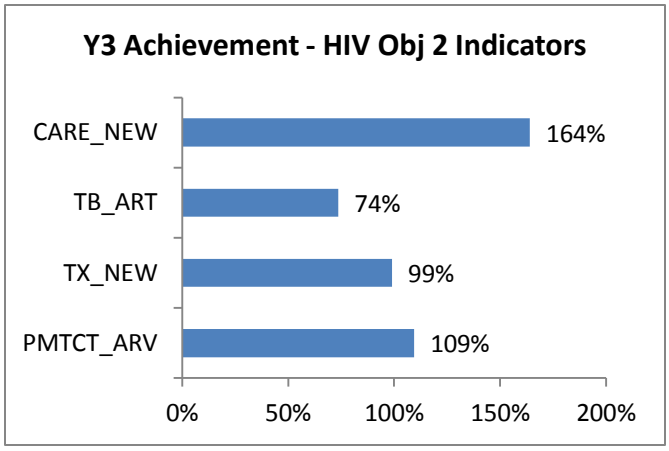


**Figure 4: Y3 Achievement for HIV objective 2 indicators.**

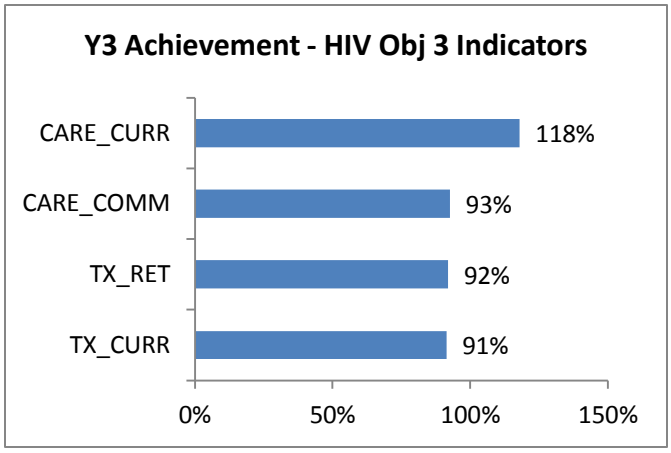


**Figure 5: Y3 Achievement for HIV objective 3 indicators.**

Finally, SSQH performed well for indicators under the HIV strategy's third objective – *to improve PLHIV retention in care and treatment services, and enhance ART adherence*. During the year, 6,093 people currently receive ART (TX_CURR), representing a 114.3% ER achievement rate. Cohort treatment retention also fared well, with 77.9% of adults or children known to be alive and on treatment 12 months after ART initiation (or 92% ER achievement for TX_RET). Retention efforts were bolstered by CHW engagement to track HIV patients at the community level and the creation of adherence support groups at aggressive intervention sites to encourage retention in care. SSQH saw 5,058 HIV+ adults and children receiving care and support services outside the health facility (CARE_COMM) for the year, a 92.6% ER achievement.

## Overview of Programmatic Activities for the Year

*Increasing HIV+ patient identification and enrollment in care and support*

During PY3, SSQH intensified its support for HIV patient identification, enrollment in care and support, and retention in treatment. Per the HIV strategy, which was refined for the year, SSQH focused its support and technical assistance on 17 sites, 14 of which have treatment capacities. Routine site mentoring visits, conducted in coordination with departmental staff, reviewed with HIV providers protocols and algorithms to encourage provider-initiated testing and counseling (PITC) to identify patients at higher risks (such as having TB, OI, or STIs), as well as index case testing to family members and partners of HIV+ patients. Patient chart reviews aided project advisors to identify with service providers missed opportunities for HTC. In the area of PMTCT, SSQH oriented newly-hired ANC staff to

HTC services and best practices. Site managers and CHW supervisors received supportive supervision on how to encourage and monitor HTC referrals made by CHWs during home visits.

SSQH augmented its support for enrolling new pre-ART and ART patients into care and treatment. Technical assistance introduced algorithms for same-day enrollment in care for patients testing HIV+, to reduce the risk of LTFU for pre-ART patients. Patient record reviews capacitated providers to identify pre-ART patients who are eligible and to set up immediate appointments to integrate them into treatment. Chart reviews also enabled SSQH advisors and providers to discuss adherence, IPT, CD4 initial/follow-up, and TB screening. Site visits and training activities focused on ensuring providers have appropriate tools and protocols[3] and receive mentoring and capacity reinforcement for their effective application.

Offsite trainings and onsite supportive supervision follow-up reinforced provider capacity to improve the quality of care and support offered to HIV patients. A master training workshop in HIV/TB co-infection and case management trained 24 participants from 17 HIV sites.[4] Once HIV providers returned to their facilities, SSQH advisors followed up with onsite mentoring and supervision visits to reinforce the application of the training's content. Using recent facility SIMS reports as a foundation, technical assistance visits covered numerous aspects of HIV/TB management and care: review of site performance; distribute and post norms and job-aide posters; review how to properly complete HIV registers; update and use of tableau de bord; distribute referral/counter-referral tools; review CQI plans and role of quality teams; and review role of ASCPs in HIV management at the community level. Project advisors and facility personnel updated plans for actionable next steps, focal point person, and deadlines for monitoring and follow-up.

Enrollment and access to care services included nutritional and pediatric support. Technical assistance site visits also reviewed service support for HIV patient nutritional care. HIV providers (including doctors, nurses, social workers, and psychologists) received a detailed overview of nutrition management for HIV patients. Practical exercises, case studies/simulations, and strategy/skills development covered both general nutritional concepts and focused nutritional management for HIV patients. Participants learned how to properly measure weight, BMI, and MUAC; examined counseling techniques for PLHIV; reviewed institutional and community nutrition activities; explored strategies for improved nutritional support for PLHIV; and received tools (i.e. referral forms) and protocols in nutrition management.

Support for health providers to identify and manage OVC cases helps ensure a supportive environment for children and families affected by HIV. A workshop for 17 HIV facility social workers, psychologists, and other providers reviewed OVC care, including case identification and enrollment in care.[5] Follow-up onsite mentoring visits reinforced OVC care and case management with providers, including patient file completion and management, organizing identification efforts and targeted testing for OVCs, and

[3] Tools and protocols cover enrollment in care, screening and treating HIV/TB co-infection, reintegrating into care LTFU patients, among other topics.

[4] The training's design covered all aspects of co-infection: it started with epidemiology & pathology; reviewed MSPP norms for screening, diagnosing, and managing TB cases; covered HIV/TB co-infection and TB infection control for HIV patients; and discussed ways to improve and encourage HIV and TB program collaboration to ensure all suspected cases are diagnosed and treated. Pre- and post-tests results showed an increased understanding of the material, moving from an average of 45% to 85% by the end.

[5] Post-test results from the training showed a 45% increase that the pre-test in the number of participants scoring between 70-100%, demonstrating an improved comprehension of OVC care.

following up on exposed infants and children. Since most sites do not have pediatricians, mentoring focuses on strengthening client identification, basic care, and referral for complex cases.

*Increasing retention in care and treatment*

SSQH focused its support for retaining HIV+ patients in care and treatment through several institution- and community-based interventions. At the site level, technical assistance targeted site managers and health providers to improve HIV patient case management, including monitoring treatment adherence, referrals and counter-referrals continued access to care, and psychosocial support services. Site managers created patient lists and service dates to improve monitoring. SSQH helped HIV sites update quality tools such as CQI plans to incorporate steps and processes for managing LTFU cases and supporting reintegration to care. During the year, 11 HIV sites expanded their CQI plans to incorporate LTFU prevention and management. Project advisors monitored implementation of the CQI plans during follow up visits. Technical assistance for lab technicians helped them address CD4 backlogs to reduce turnaround time and susceptibility for LTFU. Register reviews and data entry helped to strengthen data recording and reporting.

HIV management at the community level has historically been managed by HIV field agents and accompagnateurs, as mandated by MSPP. While polyvalent CHWs have not typically played a role in supporting HIV management, SSQH identified them as under-utilized resources that could add value in tracking HIV patients at the community level. Starting in July 2015, SSQH began training polyvalent CHWs in HIV support at two sites (Delmas 75 and Martissant). Polyvalent CHWs from three more sites received HIV training during the ensuing months: ICC – August; OBCG – September; and Finca – October 2015. By March 2016, the project had trained 139 polyvalent CHWs in HIV at 10 sites. The HIV curriculum, which the project designed, includes 10 modules covering a range of information: prevention and treatment, STIs, risk for pregnant women, stigmatization and psycho-social support, HIV/TB co-infection, and OVCs.

Once the polyvalent CHWs were trained, SSQH advisors worked with site managers and CHW supervisors to reinforce community HIV support, as they are typically the personnel who oversee the management of the facility's HIV patient load and care provision. Project advisors worked with them to list all LTFU patients and assign caseloads to polyvalent CHWs trained for HIV home visits. Site managers received tools and guidance on how to help CHWs track individual patients, remind them of appointments and offer to accompany them to the clinic, and follow-up once clinical services have been received. The mentoring teams reviewed what tools are available and used by polyvalent CHWs to track patients and how site managers and supervisors could improve usage. SSQH introduced the HIV home visit form and reinforced use of the reference/counter-reference form with supervisors and site managers; polyvalent CHWs were trained on how to use the forms.

mSanté became a promising tool to help polyvalent CHWs manage their assigned HIV patients and track those identified as LTFU. In August 2015, SSQH piloted a MSPP-approved HIV module at ICC Grace Hospital with polyvalent CHWs, and in November, introduced the module at Delmas 75. Both sites have polyvalent CHWs actively using the program tool, while polyvalent CHWs at Martissant also received training. As of March 2016, there were 62 providers trained in the HIV module at 3 sites: 5 site managers, 7 field agents, and 50 polyvalent CHWs.

Working differently than the other care modules within mSanté, the HIV module operates first through the site manager, who is in charge of HIV management, before engaging the CHW. Once a HIV patient arrives to the facility, the site manager collects information and enters it into mSanté, and then works

with the patient to assign them a CHW with whom the patient feels comfortable to work. The case is transferred to the CHW for home visit follow-up care and tracking. Through the program, the site manager and polyvalent CHW schedule home and facility visits for the HIV patient, and track the patient's adherence to the visit schedule. The HIV module also tracks important health information for the patient, such as CD4, viral load, weight, pregnancy, and TB status, as well as the patient's medication status and adherence to the regimen (as reported during home visits, not facility visits, and entered by the site manager). Patients appear in the LTFU list when at least one condition is met: missed three consecutive visits (home or clinical); has not had a visit in over 60 days if taking ARV; or has not had a visit in over 90 days if the patient is *not* on ARV.[6] Conversely, patients are removed from the LTFU list when: the patient accepts a home visit or accepted to schedule the next home visit; or the patient has surpassed three attempts. They are moved back to the HIV management list managed by the site manager.

Finally, another community-based intervention piloted during the reporting period are adherence clubs: support groups for HIV +patients designed to reinforce ART adherence through peer support, community-level delivery of ARVs, and reduce costs (time and travel) for facility visits. Adherence clubs aim to reduce the number of LTFU, improve patient reporting to clinics, provide patient education on treatment and positive prevention reinforcement, and directly involve patients in their case management. Currently, Delmas 75 and Martissant, two sites identified in the SSQH HIV strategy for aggressive intervention, have adherence clubs established. SSQH advisors helped site managers establish dates and planned activities for adherence clubs, and participated during the meetings. Club activities included verifying the adherence of the participants, providing them with motivation to continue, offering clinical evaluations (thereby eliminating wait time), and distributing ARVs.

Future Considerations

SSQH recommends USAID make the following considerations as it moves forward. Several initiatives started under the project, but will need further reinforcing and management. Support for community-based HIV management proves to be a promising approach to reducing LTFU. USAID should consider working with PEPFAR-supported sites to fully integrate this support in its service delivery. Polyvalent CHWs need more HIV training and supportive supervision should strengthen the management process between site managers and CHWs to ensure client tracking. The adherence groups started at a few sites should be scaled up and reinforced as well. Only a handful of sites started this but SSQH's scope changed before they could take firm root at the sites.

Data management continues to be an area in which sites need ongoing reinforcement. Quality checks and data use practices should be regularly integrated into site-level support. SSQH worked in these areas, and recommends USAID invest further in this domain. Additional data management recommendations can be found under Management, Monitoring, and Administration.

Finally, USAID should identify how it wants to support clients who receive treatment and care from sites being transitioned from PEPFAR support. Recent changes in PEPFAR's requirements of supported sites and client load fundamentally change the care people can receive at lower volume sites. USAID should identify how these clients will access care in the face of transitioned sites and budget constrictions. Support for referral networks that specifically target these clients may be an option worth exploring.

[6] It is important to note that LTFU as measured by mSanté is different than LTFU as recorded in MESI, as mSanté considers both facility and home visits. MESI data is also updated on a rolling basis and often has a reporting lag. As such, numbers tend to differ between the two platforms.

## TUBERCULOSIS

| TB Indicator Performance Summary Table | |
|---|---|
| **Exceeded >110% of Expected Result (N = 2)** | Case notification rate in new sputum smear positive pulmonary TB cases per 100,000 population in USG-supported areas (TB01): **220** or **198.1% ER achievement** |
| | % of the estimated new smear-positive pulmonary TB cases that were detected under DOTS (TB02): **129.3%** or **193% ER achievement** |
| **Below 90% of Expected Result (N = 2)** | % of project-supported facilities that have adopted an infection-control plan (TB03): **63.8%** or **63.8% ER achievement** |
| | % of PLHIV newly enrolled in HIV clinical care who started isoniazid preventative therapy (IPT) (TB04): **66.7%** or **70.2% ER achievement** |

**Table 2: TB Indicator Summary Table**

Overview of TB Indicator Results

TB indicator performance was mixed for the year, posting exceptional results for some while falling short of ERs for others. Health providers within the SSQH network continued their strong performance in identifying and treating new smear-positive pulmonary TB cases. The year's case notification rate for new sputum smear positive pulmonary TB cases out-performed ER for the second consecutive year (198.1% ER achievement). The case detection rate detected under DOTS also surpassed expectations, attaining 193% ER achievement. This performance suggests that more TB cases are being newly identified at SSQH sites than the estimated national prevalence rate.

Yet not all TB indicators met their ER for the year, despite strong efforts. While SSQH helped 25 facilities update or develop infection control plans during the first semester, increasing its result from last year by 21.3%, it still only yielded a 63.8% achievement of the PY3 target. With the change in project scope in April, SSQH had to suspend efforts to increase the number of sites with infection-control plans. Preventive therapy for newly enrolled PLHIV also did not meet its ER, with 66.7% receiving isoniazid preventive therapy (70.2% ER achievement). Questions about some of the site-level data for this service remain, and it would be prudent for more TA focused on monitoring IPT provision for new HIV patients and capacity reinforcement for providers. Sites such as Delmas 75 and OBCG report strong performance (93.3% and 98.3% respectively). However other sites such as ICC and SADA Matheux did not (44.4% and 6.6% respectively).

TB Diagnostic and Treatment Services

In coordination with PNLS, DDS, facilities, and community-based services, SSQH supported the intensified case identification, notification, and treatment of TB patients. Working at the departmental level, project advisors conducted joint meetings to help define strategies and plans for linking HIV resources to support TB services and to identify diagnostic equipment needs. SSQH coordinated with the departments to ensure availability of TB protocols at sites, while SSQH advisors mentored site personnel in their application.

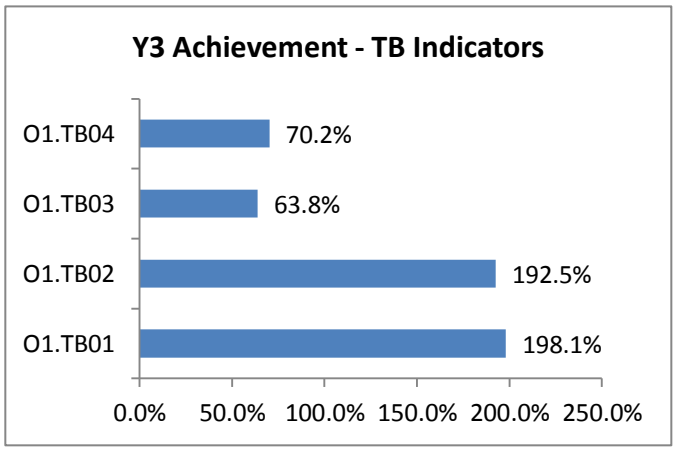


**Figure 6: Y3 Achievement for tuberculosis indicators.**

However, equipment and supply shortages hindered some sites' ability to consistently adhere to protocols and limited diagnostic capabilities. The project coordinated with SCMS and MSPP institutions for equipment needs, but demand often surpassed supply. To address this, SSQH included select equipment to support TB services on the procurement plan submitted to USAID in August 2015. Procurement is managed by the USAID/LMG project on behalf of SSQH, and equipment distribution occurred during the second semester.

Site level TA focused on addressing co-infection to reinforce TB screening for HIV patients and the enrollment in treatment of those testing positive. A five-day workshop targeted providers from 14 sites on reviewing MSPP norms and protocols to support their implementation at sites. Onsite mentoring visits reinforced the application of this material. ASCP trainings covered community outreach, active case identification strategies, and instructions for making appropriate referrals for diagnosis and treatment.

TB Infection Control

Infection control and waste management are foundational for quality service provision, but SSQH facilities have not always had the proper tools, procedures, and equipment to implement them. When SSQH started in October 2013, very few facilities had infection control plans defined and implemented. Since then, SSQH has increased significantly the number of facilities with established plans and provided onsite mentoring to reinforce their implementation. By the end of PY2, 34 facilities had infection control plans. By the end of the PY3 first semester, 51 facilities had plans developed. Building off the infection control plan template developed in PY2, SSQH expanded the tool to incorporate waste management elements and tailored content based upon service level (disp., CSL, CAL, and HCR). During the reporting period, 25 sites updated/developed infection control/waste management plans and received reinforcement of waste management practices and principles[7]. These plans identify actions, responsible persons, and deadlines for clarity and accountability. Once these tools were updated, SSQH advisors provided onsite supportive supervision visits to monitor use of the tools and reinforce provider capacity. During these visits, project advisors review infection prevention and waste management steps, refresh providers in knowledge of collecting, handling, and managing waste, and identify areas of weakness and outline course correction steps.

However, even with plans in place, adherence can sometimes be problematic. Site personnel identified for managing key infection control tasks do not consistently perform their duties, and more support is needed to reinforce their capacity and monitor their performance. Additionally, many sites experience regular stock outs of basic infection prevention supplies such as masks and gloves. While SSQH coordinated with DDS and other partners to respond to these shortages and provide supplies, stock outs still occurred and hampered infection prevention efforts.

[7] Infection control/waste management plans include six categories: management of controlling waste and infection; training needs (initial and ongoing); hygienic practices of personnel; management of the physical environment; monitoring and reporting; and additional support.

## MATERNAL AND CHILD HEALTH

| MCH Indicator Performance Summary Table | |
|---|---|
| **Met 90% - 110% Expected Result (N = 5)** | % of births attended by a skilled doctor, nurse or midwife (MCH02): **20.4%** or **97.2% ER achievement** |
| | Prevalence of anemia among pregnant women (MCH03): **11.0%** or **90.6% ER achievement** |
| | % of underweight children under 5 years of age (MCH12): **5.1%** or **102.5% ER achievement** |
| | % of children who received DPT3 vaccine by 12 months of age (MCH08b): **66.7%** or **102.5% ER achievement** |
| | No. of women reached with exclusive breastfeeding messages (MCH15): **57,813** or **91.9% ER achievement** |
| **Exceeded > 110% of Expected Result (N = 2)** | % of postpartum / newborn visits within 3 days of birth (MCH04): **84.2%** or **140.4% ER achievement** |
| | No. of children who received DPT3 vaccine by 12 months of age (MCH08a): **49,403** or **136.3% ER achievement** |
| **Below < 90% of semi-annual target (N=7)** | % of women who received at least 3 antenatal care visits during pregnancy (MCH01a): **41.8%** or **81.9% ER achievement** |
| | % of women who received 3+ antenatal care visits during pregnancy (MCH01b): **34.9%** or **69.8% ER achievement** |
| | % of children aged <1 year that are fully vaccinated in project catchment areas (MCH07): **53.7%** or **56.5% ER achievement** |
| | Prevalence of exclusive breastfeeding of children under 6 months of age (MCH06): **36.2%** or **54.9% ER achievement** |
| | No. of children < 5 who reached by USG-supported nutrition programs (MCH09): **253,752** or **57.2% ER achievement** |
| | No. of children < 5 who received Vitamin A from USG-supported programs (MCH10): **167,049** or **87.3% ER achievement** |
| | No. of newborn infants receiving antibiotic treatment for infection through USG-supported programs (MCH16): **1,790** or **76.6% ER achievement** |
| **No Reporting for Period (n=2)** | No. of individuals trained to implement improved sanitation (MCH13): no reporting as per the SSQH PMP Indicator with PY3 Reporting document submitted to USAID in April 2016. |
| | No. of people trained in child health and nutrition through USG-supported programs (MCH14): no reporting as per the SSQH PMP Indicator with PY3 Reporting document submitted to USAID in April 2016. |

**Table 3: MCH Indicator Summary Table**

Overview of MCH Indicator Results[8]

Overall, maternal health indicator performance posted mixed results, with some achieving their annual ERs and others not. SSQH reached 57,813 women with exclusive breastfeeding messages during their first prenatal visit (91.9% ER achievement), a slight increase from PY2 result of 56,097. The prevalence of anemia was 11%, a 90.6% ER achievement. Significant increases from PY2 in the percent of births attended by a skilled doctor, nurse, or midwife were noted, with 20.4% for the year (97.2% ER achievement). However, this increase may be explained in part due to SSQH using a new data source for the period (SISNU). The percent of postpartum / newborn visits within 3 days of birth greatly surpassed expectations, with 84.2% receiving services (a 140.4% ER achievement). Conversely, the percent of women receiving at least 3 and 3+ antenatal care visits did not meet annual targets (41.8% or 81.9% ER achievement and 34.9% or 69.8% ER achievement respectively). This represents a decrease from the PY2

[8] In PY3, SSQH shifted from USAID-DHIS2 to MSPP-SISNU HIS as a result of MSPP's directive that sites should exclusively submit their monthly statistical reports to the Departments.

performance, which may in part be explained by the new data source used in PY3. Finally, the prevalence of exclusive breastfeeding of children under six months fell short of annual expectations (36.2% or 54.9% ER achievement).

**Figure 7: Community Health worker weighs baby in village.**

Child health and nutrition indicators also posted mixed results. The number and percentage of children who received DTP3 vaccination by 12 months of age both surpassed expectations (49,403 or 136.3% ER achievement and 66.7% or 102.5% ER achievement respectively). Similarly, the percent of underweight children did well (5.1% or 103.5% ER achievement). The number of children under five who received Vitamin A came very close to meeting its annual target, with 167,049 or 87.3% ER achievement. However, several CH indicators did not perform as desired. The percent of children aged < 1 year who are fully vaccinated was only 53.7% or 56.5% ER achievement. It is clear that the annual target for this indicator is unrealistic and does not align with related indicator targets: DPT3 target coverage is only 65% yet full vaccination (which includes DPT3) is 95%. The number of children under 5 reached by nutrition programs was 253,752 or 57.2% ER achievement. This stark decrease from the PY2 result can only be explained by the changed data source in PY3, as SSQH did not note any major problems providing this service. Finally, SSQH reported "n/a" for two training indicators (number of people trained in improved sanitation methods, and child health and nutrition) because these activities were suspended in April with the changed project scope and results could not be annualized.

Indeed, data sets proved problematic: SSQH found that SISNU did not have complete data for most MCH indicators. SSQH supplemented SISNU with MSPP monthly statistical reports from NGO partners and conducted DQA and data collection at the Departments for selected indicators.

<u>Maternal and Neonatal Health</u>

SSQH continued its support for basic MNH care at community and institutional levels through service delivery, provider trainings, and TA to augment the quality and demand for MNH services. Project advisors conducted mentoring and supervision visits at 16 sites during the first semester, reinforcing

institutional and community-based providers in prenatal care, management of delivery complications, and post-natal/essential newborn care. With many of the facility providers also staffing the mobile clinics, this mentoring also reinforced community-based care. Collaboration with MCSP produced concrete results for SSQH personnel: 119 health providers received training in maternal mortality prevention, early danger signs in pregnancy, AMSTL, safe delivery best practices, infection prevention, and postnatal and essential newborn care.

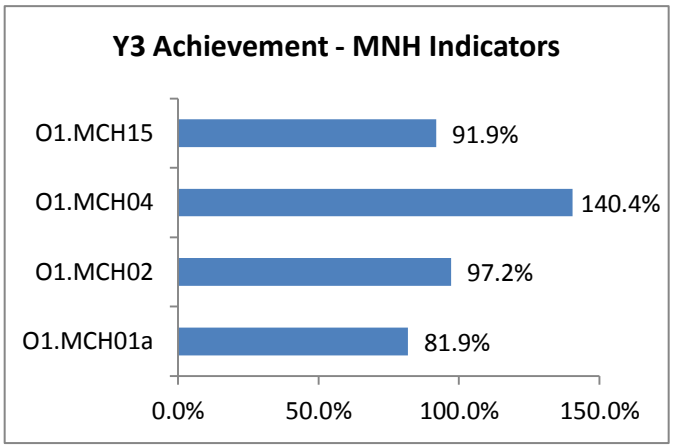


**Figure 8: Y3 Achievement for maternal neonatal health indicators.**

At the community level, a total of 904 polyvalent CHWs since the project's start received training to recognize and identify danger signs of pregnancy and anemia, promote the importance of breastfeeding and iron and folic acid supplementation, and to refer cases via MCH networks as appropriate, as per the MSPP curriculum. Polyvalent CHWs provide basic yet essential MNH services through home visits and rally posts, identifying pregnant women and encouraging them to visit sites to have ANC care, as well as visit mothers who have recently delivered to provide postpartum care. Polyvalent CHWs trained and supported to use *mSanté* accessed job aides to facilitate MNH consultations.

Child Health and Nutrition

Support for facility and community-based child health and nutrition services continued this semester. Considerable attention was given to reinforcing HIV provider capacities to monitor and manage patient malnutrition. SSQH advisors and facility providers discussed the importance of nutrition in HIV care, how to monitor patient nutritional health, and special nutritional considerations for HIV+ children and pregnant women. Practicum exercises reinforced capacities in how to properly measure and record patient weight, MUAC, and BMI, and provide nutritional counseling. Mentoring exercises helped providers develop strategies for boosting nutritional support at the community level, including nutrition management for HIV patients being tracked by CHWs. During the period, SSQH trained 97 CHWs in active malnutrition screening using anthropometric measurements at community events (rally posts and home visits). SSQH advisors facilitated distribution of 106 boxes of Plumpy Nut nutritional supplement in coordination with DDS and UNICEF to selected sites. SSQH also distributed vitamin A stocks (6,500 caps of 100,000 UI and 20,000 caps of 200,000 UI) at 17 sites. Finally, SSQH coordinated with LMG to procure for sites 38 pediatric scales, 60 pediatric stethoscopes, and 78 pediatric thermometers, all of which were distributed during the second semester.

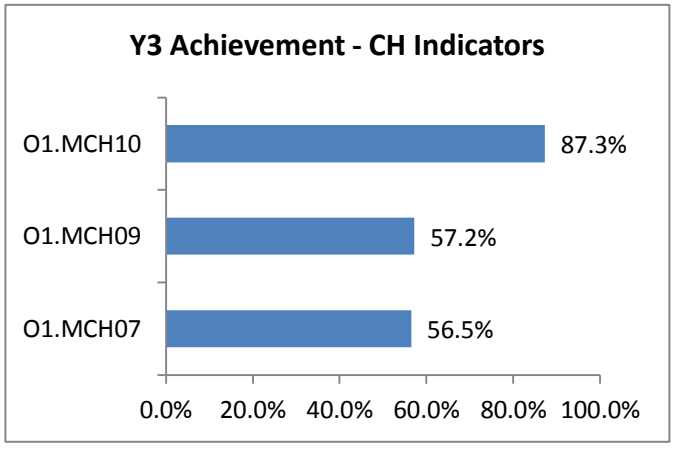


**Figure 9: Y3 Achievement for child health indicators.**

Site mentoring visits surveyed tools and resources available for vaccination and malnutrition programs, including availability of deworming drugs, syringes, antigens, and vitamin A. TA to facility personnel

reviewed and shared best practices for using tools such as vaccination daily journals and inventory management forms. Project advisors worked with site providers and managers on infant and young child feeding best practices and reinforced correct and consistent usage of growth monitoring and reporting tools, including technical forms, national registers and dashboards, activity calendars, and monthly reports.

Water, Sanitation, and Hygiene

SSQH completed several light infrastructure improvements at project-supported sites during the first semester. Six (6) facilities had work completed to address waste management issues and repair broken or non-functioning water systems/sanitation blocks. The project replaced toilets, sinks, and plumbing; built new waste disposal pits; graded facility courtyards and installed improved drainage; and installed a rain catchment system. A full list of projects completed is found under Objective 3 – General Facility Management.

Project advisors supported 25 facilities to develop or upgrade waste management plans. During two workshops during the first semester, SSQH worked with facility staff to develop plans that build from previously-existing infection control templates and add waste management elements. The plans identify general waste management principles/practices, identify training needs, review hygienic practices of personnel, discuss the management of the facility's physical environment, and outline monitoring & reporting steps. Once the plans were developed, SSQH advisors conducted onsite mentoring visits to assist site personnel in implementing the plans and reinforcing capacities in infection control and waste management. Training of polyvalent CHWs in WASH content also continued during the semester. A total of 164 CHWs (from CS Tayfer, HHF, SADA, St. Paul, and Dame Marianne) received instruction and capacity reinforcement in effective waste management at both facility and community levels, and the impacts upon health.

## FAMILY PLANNING AND REPRODUCTIVE HEALTH

| **FP/RH Indicator Performance Summary Table** | |
|---|---|
| **Met 90 – 110% of Expected Result (N=1)** | % of USG-assisted services delivery sites providing FP counseling and/or services (FP03): **100%** or **100% ER achievement** |
| **Exceeded > 110% of Expected Result (N=1)** | No. of youth (aged 15-25) accessing reproductive health services (FP04): **104,492** or **199.6% ER achievement** |
| **Below <90% of Expected Result (N=2)** | Modern method contraceptive prevalence rate (MCPR) (FP01): **19.5%** or **62.5% ER achievement** |
| | Couple Years Protection in USG-supported programs (FP02): **314,268** or **62% ER achievement** |

**Table 4: FP/RH Indicator Summary Table**

Overview of FP/RH Indicator Results

While FP/RH indicators posted mixed results vis-à-vis their annual targets, performance increased from the PY2 results. Both MCPR (19.5% coverage) and CYP (n=314,268) showed gains from last year. Likewise, the number of youth (aged 15-25) accessing RH services increased (n=104,492), widely surpassing its ER. While some of this increase should be attributed to intensified support during the year (ongoing FH/RH trainings, mentoring, and community mobilization), the potential role of a changed data source should be noted. Finally, SSQH achieved 100% of eligible sites offering FP services; only three religious institutions did not, as set by their mandate.

Contraception Use and Availability

A central focus for SSQH is to increase access to and use of modern contraception among women of reproductive age. To support this, project interventions included facility- and community-based provider trainings, site-level action planning, departmental coordination and joint supervision, and commodity management. During PY3,70 sites have regular FP activities at the community level in their annual work plans. Of these sites, 64 offer at least four contraceptive methods (condoms, pills, injectables, and implants), while 18 sites offer these methods plus IUDs. This last figure represents quite an achievement, as the project increased the number of sites providing IUDs by 100% last year. Five (5) sites offer permanent methods.

Trainings aimed to build the capacity of providers to offer method mix and make referrals as appropriate. The trainings included DDS technical staff and MSPP/DSF personnel when possible. Twenty-four (24) providers participated in a workshop designed to train site managers to verify use of checklists for quality FP service provision (including quality of counseling, confidentiality, management of side effects, and availability of methods). As part of the ASCP trainings, 164 received instruction on providing FP and referring clients for LAPMs at facilities. Supervision visits also reinforced provider capacities and monitored USG compliance activities.

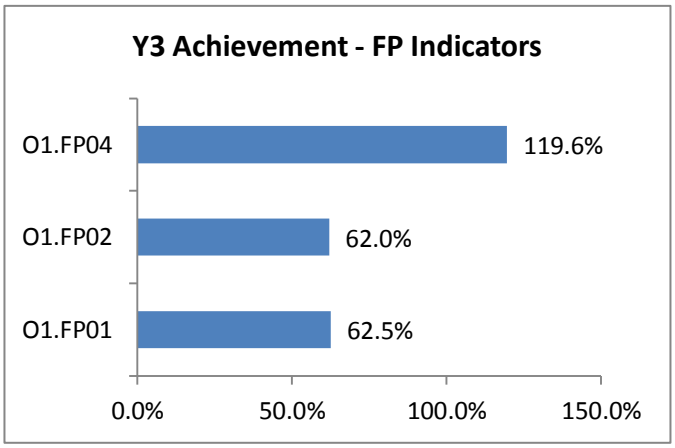


**Figure 10: Y3 Achievement for family planning/reproductive health indicators.**

Youth-friendly reproductive health services continued during the semester. Technical assistance visits targeted 21 sites during the semester to reinforce RH services for youth (aged 15 – 25). Advisors considered the number and type of providers on site, hours of operation, separate space for serving adolescents. Technical assistance to reinforce the integration of FP services with HIV, maternal health, and GBV services for key populations such as commercial sex workers continued. FOSREF has several MARPs and youth centers within the project's catchment area. Onsite mentoring in FP integration at these centers improves services provided while strengthening referrals to SSQH network sites for follow-up care.

In terms of commodity availability, IUD stock outs are not a major concern, as MSPP and SCMS have committed to ensure their availability across the network. Yet despite the availability of IUDs, not every site with properly trained personnel to deliver the method can do so. Basic medical supplies needed to perform IUD insertions (e.g., Betadine, gauze, gloves, and bleach) are not always on hand, which prevents providers from delivering this service. Limited facility budgets prevent them from purchasing

these supplies directly, thus making them dependent on outside sources for their provision. In February, with support from SSQH, USAID announced it was going to provide consumable commodities for a period of 12 months, an important development in support of FP service availability.

**Figure 11: Community Health workers counsel young women and mothers on contraceptive methods.**

USG Compliance

USG Compliance activities continued through the year. Project staff received an annual training In USG legislative and policy requirements for FP. During the first semester, SSQH conducted 36 compliance visits and held an annual workshop on USG regulations for service delivery staff. Monitoring visits showed an understanding of the regulations among site providers, but revealed needed areas for improved documentation and highlighted gaps between some NGO central bureaus and their affiliate service delivery sites. Strengthening the monitoring and technical support relationship between NGO central bureaus/DDS and service delivery sites is a keystone in ensuring compliance across the project network, as the project relies on the former to monitor compliance for their sites. Much of SSQH PY3 efforts have focused on this.

## GENDER-BASED VIOLENCE AND CHILD PROTECTION

| GBV/CP Indicator Performance Summary table | |
|---|---|
| **Met 90% - 110% of Expected Result (N=1)** | % of health institutions providing clinical assistance and referrals of child protection cases to legal and social services (GBV02): **28** or **90.3% ER achievement** |
| **Exceeded >110% of Expected Result (N=2)** | No. of people reached by a USG-funded intervention providing GBV services (GBV01): **423** or **>200% ER achievement** |
| | No. of children reached by child protection services (GBV03): **6,362** or **136% ER achievement** |
| **No Reporting for Period (n=1)** | No. of community and clinical health staff and community-based actors trained to recognize and refer GBV and child protection cases to appropriate legal and social services (GBV04): no reporting as per the SSQH PMP Indicator with PY3 Reporting document submitted to USAID in April 2016 |

**Table 5: GBV/CP Indicator Summary Table**

Overview of GBV/CP Indicator Results

The year yielded better-than-expected results for a couple GBV/CP indicators, with GBV services reaching 423 people (>200% ER achievement) and child protection services reaching 6,362 (136% ER achievement). Due to challenges in documenting GBV/CP services, SSQH relies upon OVC and clinical cases of violence for its data. For the period, 28 supported facilities provide clinical assistance and referrals of CP cases to legal and social services (90.3% ER achievement). Finally, no data is reported for the number of providers trained to recognize and refer GBV and CP cases, due to the change in project scope and the suspension of related activities in April 2016.

GBV/CP Activities

During the year, 6,362 OVCs benefitted from child protection services, representing a 136% ER achievement rate. For the year, 164 providers and polyvalent CHWs received training on child protection, including interview techniques and social work services. Polyvalent CHWs at selected sites incorporated OVC follow-up during their HIV patient home visits. SSQH provided coaching and mentoring to providers, psychologies, and social workers who routinely serve OVCs, and helped link them with benefits of the USAID/BEST project. This helped ensure OVCs benefit from support for schooling, participation in mothers' and children's' clubs, and recreational activities.

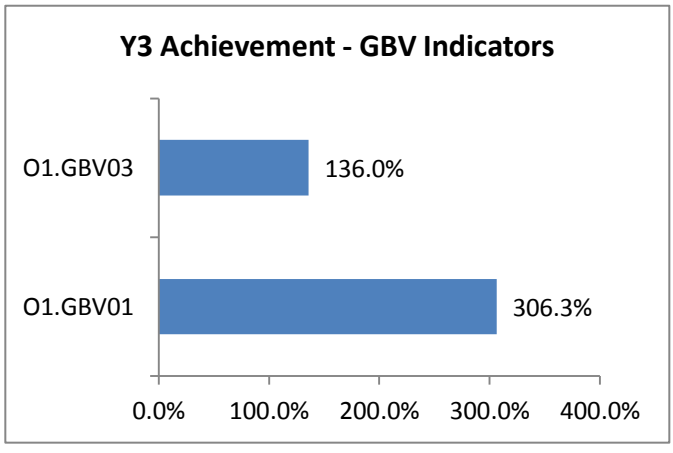


**Figure 12: Y3 Achievement for gender-based violence and child protection indicators.**

SSQH continued its capacity reinforcement for GBV/CP services at selected facilities. Project advisors worked with social workers, psychologists, and nurses to strengthen services and referrals. At the community level, project advisors coordinated with community leaders in GBV awareness sessions. Ninety-nine (99) community members, including police officers, religious leaders, school directors and judges, participated in awareness sessions and received resources on GBV.

## CRITICAL CARE

| Critical Care Indicator Performance Summary table | |
|---|---|
| **Exceeded >110% of Expected Result (N=1)** | % of project-supported sites offering at least one critical care service (CC01): |
| **Below < 90% of Expected Result (N=1)** | % of sites demonstrating improvement in critical care practices (CC02): |

**Table 6: Critical Care Indicator Summary Table**

Overview of CC Indicator Results

Critical care indicators split performance for the year. With recent changes to their definitions, the indicators examine critical care services at HCRs and CALs (n=18). The most common critical care service cluster offered at sites is EmONC , and project TA during the year mentored providers and reinforced the quality of said services. The percent of project-supported sites offering at least one critical care service was 61.1%, or 154.5% ER achievement. Despite TA reinforcing critical care services, in particular EmONC, SSQH was not able to adequately document improvements in care practices during the period.

Support for Critical Care Services

SSQH focused its support for critical care services on improving provider capacities to manage emergency obstetric care. Project advisors mentored providers at sites to manage abnormal deliveries, including how to monitor the baby's position and heartbeat, and the quality of the amniotic fluid, as well as proper techniques for performing Cesarean operations. Site visits confirmed presence and functionality of basic equipment necessary to properly deliver EmONC services. Sites also benefitted from offsite trainings in partnership with MSCP to reinforce safe delivery best practices, while onsite TA helped sharpen and maintain quality tools such as CQI plans, in which critical care services elements are incorporated.

## COMMUNITY-BASED ACTIVITIES

| Community-Based Activities Indicator Performance Summary table | |
|---|---|
| **Exceeded > 110% of Expected Result (N=2)** | Total number of clients accessing services provided by project-supported facilities or CHWs (CB04): **2,506,131** or **131.1% ER achievement** |
| | % of health referral networks with UAS coordinator supervisory visit documenting quality improvement in the last 6 months (CB06): **72.2%** or **>200% ER achievement** |
| **Below < 90% of Expected Result (N=2)** | No. of sites providing care and support for vulnerable groups (CB01): **17** or **51.5% ER achievement** |
| | No. of households with soap and water at hand washing stations commonly used by family members in USG-assisted programs (CB07): **56,639** or **35.6% ER achievement** |
| **No Reporting for Period (N=2)** | No. of service providers trained who serve vulnerable persons (CB02): no reporting as per the SSQH PMP Indicator with PY3 Reporting document submitted to USAID in April 2016. |
| | No. of USG-supported communities establishing an emergency transport system for pregnant women: no reporting as per the SSQH PMP Indicator with PY3 Reporting document submitted to USAID in April 2016. |

**Table 7: CBA Indicator Summary Table**

Overview of CBA Indicator Results

Community-based activity indicators posted split results for the year, with two exceeding their ERs and two unsuccessfully meeting theirs. A large success for SSQH was the total number of clients accessing services provided by facilities and CHWs, which reached 2,506,131 for the year, or 131.1% ER achievement. This is a sharp increase from last year's result, which while coinciding with the project's augmented engagement of CHWs in new areas of support such as HIV management, can only be explained by the changed data source (SISNU) in PY3. The percent of health referral networks (HRN) with DDS personnel supervisory visit documenting quality improvement also did well, with 72.2% of HRNs (n=13) qualifying as of March 2016 (yielding a >200% ER achievement).

However, two indicators did not reach their ERs. While two additional sites were recorded to provide care and support for vulnerable groups (n=17) compared to last year's result, SSQH was not able to increase the number to meet its ER (51.5% achievement). There are cost implications with adding related services, such as staffing and training, and SSQH focused PY3 investments in scaling up HIV support. The number of sites providing care and support for vulnerable groups includes all 17 HIV sites offering OVC services. While a number of sites received capacity support for KP-friendly services, they do not have specifically-organized activities designed to target and increase demand of KP groups (i.e. sex workers), and cannot be counted for the indicator. This would include outreach groups and periods of service reserved specifically for KPs.

The number of households with soap and water at hand washing stations commonly used by family members also did not meet its ER (56,639 or 35.6% ER achievement). Yet SSQH does not conduct any activity that would directly contribute results to this indicator, so it is difficult to critically examine performance. Finally, SSQH reports "N/A" for two indicators for which activities were suspended as a result of the changed scope and its inability to have a full period of performance. Both trainings in serving vulnerable populations and community mobilization activities for emergency transport systems were not finished before the project scope changed, and subsequently had to be dropped.


**Figure 13: An ASCP uses *mSanté* during a home visit.**

Community Engagement

SSQH continued implementation of its community mobilization strategy, which espouses self-reliance and active participation of communities in the identification and resolution of perceived community health priorities. The identification process is a dynamic one and may vary from community to community, and from year to year. That is why the SSQH community health strategy underscores the importance of setting up permanent mechanisms such as community health committees at the community level to assess needs on a regular on-going basis. Moreover, the project successfully used the Pathway to Change (P2C) tool and methodology[9] to inform the strategy. During the last year, the project engaged providers at ZCs. The results from the P2C exercises led to the development, in collaboration with MSPP counterparts, of specific counseling messages for key health behaviors, barriers and facilitators.

Priority foci services initially identified by SSQH communities included: Maternal and Child Health; Child Protection and Gender-Based Violence; HIV and STIs; and Family Planning. The SSQH Community Mobilization Strategy was incorporated into and is reflected in the project's overall HIV strategy which harnesses and builds upon home visits, community support groups (i.e. *clubs des meres, youth groups*), mSanté, psychosocial services, and peer accompaniment to reinforce and promote service delivery.

SSQH began activity planning to support the development of emergency transportation committees and systems in communities linked to eight (8) facilities. Project advisors used the SSQH operation guide for establishing emergency transport committees to plan activities, which identifies CHWs as critical links between communities and facilities. The guide outlines committee member criteria (including roles, responsibilities, and likely participants), mapping exercises, awareness activities (including type, location, and facilitator), and developing a transportation plan. However, these activities did not lead to established transport systems for the year. All community mobilization activities were suspended as of April 2016.

Community-based Services

During PY3, the support for community-based services continued through service delivery agreements (NGOs and ZCs) and ASCP trainings. Since project inception, 904 polyvalent CHWs completed the MSPP modular course, and 62 providers completed HIV management training that focused on community education and follow-up of PLHIV at the community level. During the semester, 18 CHW supervisors responsible for implementation of community health activities received onsite mentoring in organizing and managing CHW work and caseload. Decentralization of services to the lowest possible level occurred through facility-led mobile clinics and community health agents, who conducted home visits, organized rally posts, and referred clients to service delivery sites in the project catchment areas. Technical assistance to CHW supervisors was reinforced by the expansion of mSanté to include a CHW supervisor module that was used in formal training sessions. The mSanté program further helped to improve the quality of data collection at the community level and linked results to referral facilities.

[9] P2C is a board game designed by Pathfinder International to engage community members to identify facilitators and barriers to service access and use. SSQH has oriented MSPP and individual DDS on the use of P2C and has incorporated the tool in ASCP trainings. The MSPP has even adapted the tool for its own use.

# OBJECTIVE 2
## IMPROVE THE FUNCTIONALITY OF THE USG-SUPPORTED HEALTH REFERRAL NETWORKS

Annual Highlights:

- ✓ 904 polyvalent CHWs graduated as ASCPs
- ✓ 800 polyvalent CHWs received certificates, backpacks, ponchos, and flashlights
- ✓ 133.3% of PY3 target achieved for number of referral network sites using mobile diagnostics

### SUPPORT FOR CHWs

SSQH supports community service delivery through two key approaches: reinforce the capacity of CHW supervisors to manage community services; and capacitate and equip polyvalent CHWs to effectively deliver services. To buttress community service management, SSQH complemented CHW supervisor trainings completed last year with onsite mentoring visits to reinforce the application of management practices. During the reporting period, project advisors met with 18 community service coordinators and CHW supervisors to review the strategy, organization, and monitoring processes in place. Advisors used the "CHW Supervisor Mentoring Checklist" to verify CHW management, and make appropriate recommendations. Key topics covered during the mentoring visits include verification of: tool availability and use to monitor CHW activities; service register completion; organization of services; the use of mSanté to monitor home visits and referrals made by CHWs; CHW engagement in HIV management support; and use of norms for completing home visits and rally posts. SSQH advisors recommended actions, and ensured focal points and deadlines were assigned to encourage progress; these subjects then become the focus for subsequent mentoring visits.

As part of SSQH's support for the delivery of community-based services, CHWs receive training in the MSPP curriculum to become polyvalent CHWs and supplies (including backpacks, flashlights, t-shirts, and rain ponchos) to assist them in their work. To date, SSQH has trained 904 polyvalent CHWs, all of whom graduated this year. These graduation ceremonies are presided over by the Departmental Directors and support personnel. Of the 904 graduated, 800 received MSPP certificates and supplies. Plans for certifying and equipping the remaining 104 polyvalent CHWs were suspended in April when the project scope changed.

mSanté

By March 2016, SSQH has trained 651 polyvalent CHWs, supervisors, and site managers in mSanté and provided them with either phones or tablets. Among this list, SSQH trained 181 polyvalent CHWs and 47 supervisors (13 refreshers) during the reporting period. An additional 15 trainer of trainers received training on mSanté, including the HIV module, during this time as well.

In December 2015, SSQH received 250 additional smart phones and chargers originally purchased to replace some of the tablets purchased earlier in the project, whose quality and durability did not meet the project's requirements. However, given a change in priorities for the period, SSQH decided to use these 250 units to train new sites in mSanté. With the recent decision by MSPP to select mobile DHIS2 over mSanté as the national CHW reporting tool, SSQH has held off from procuring more devices.

A key development in the future of mSanté occurred in January 2016, when MSPP/UEP decided it was not going to use mSanté as the preferred community data collection tool. Without MSPP's full support of mSanté, the program's effectiveness is compromised, as CHWs will still have to enter official data via the paper-based registers. This presents a reporting burden for community agents, as they use both registers and mSanté for the same reporting, which duplicates efforts and deters continued usage of the mobile application. Further challenges involving hardware malfunction prevented some CHWs from sustained program usage.

Given the lack of MSPP's interest in using mSanté as a community data collection/reporting tool, the full potential of the program cannot be harnessed and the complaint by CHWs of "double reporting" will continue. As such, SSQH has revised its objectives for the program during PY3. Activities have shifted from the initial goal of scaling the program to 1000 polyvalent CHWs, to refocusing investments in bringing to scale usage of the HIV module at the 17 HIV sites. Instead, by focusing on scaling the program at HIV sites, SSQH will articulate mSanté's value added as job aid tool that can help improve service and referral quality, including the active tracking of LTFU patients.

Nonetheless, SSQH has developed a series of resources for MSPP and USAID if ever the decision was made to bring a national mSanté program to scale. SSQH has already opened the license for partners to use mSanté, and the project has developed a collection of training, application, and monitoring materials as well as a costing and business model MSPP could use to bring the program to scale nationally within five years.

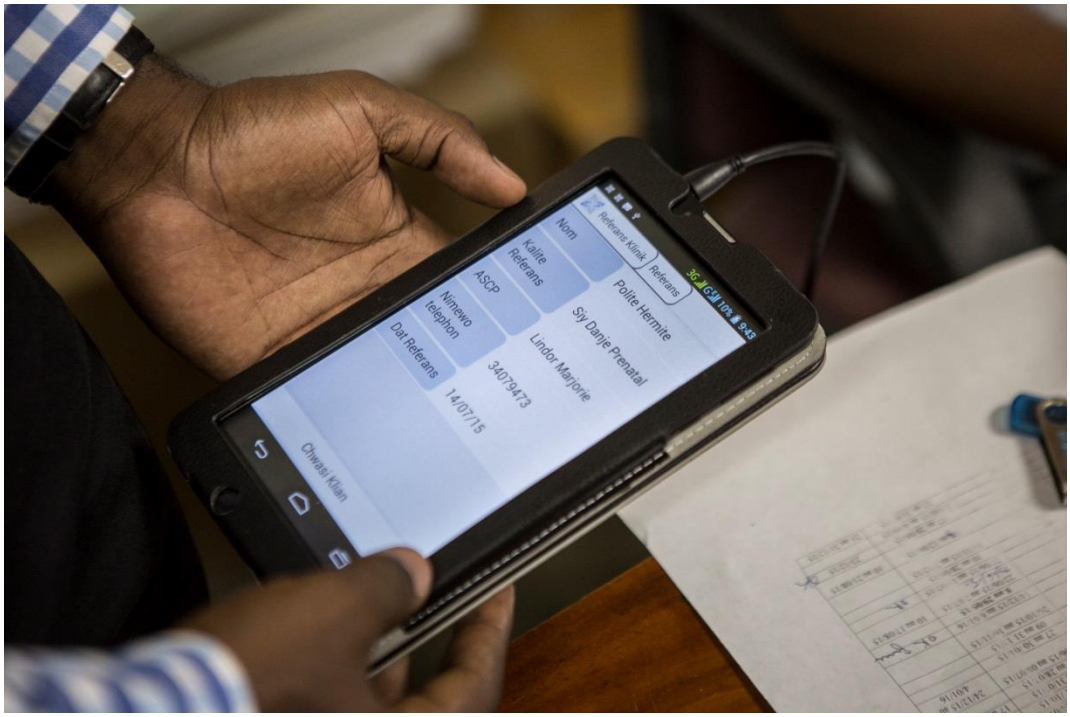


**Figure 14: An ASCP uses *mSanté* platform for referral.**

## POINT-OF-CARE DIAGNOSTICS FOR HIV/TB

SSQH successfully added ICC Grace as a point-of-care diagnostic hub facility this semester, bringing the total number of facilities with PIMA onsite to four. With a high level of HIV patients, a central location in the Port-au-Prince area, and a slow referral process to Hôpital de la Paix that took up to two days for

results, ICC was a logical selection for adding a PIMA CD4 unit. SSQH coordinated with SCMS to deliver the unit and provided laboratory and clinical mentoring to capacitate providers in its usage. The facility now has a wait time of less than 30 minutes, significantly reducing opportunities for LTFU. ICC now serves as a site backup for Delmas 75, which uses the national lab for the tests. If there is a delay with the national lab, Delmas 75 sends its tests to ICC Grace. ICC joins Dame Marie, Jules Fleury, and Bonne Fin as sites with PIMA units. Other HIV sites access CD4 testing capacities via the referral network. One challenge faced this semester is Abricots' access to the PIMA testing at Dame Marie. Transportation issues and a referral process requiring more support present obstacles.

**Figure 15: A graduated ACSP with supplies.**

**Figure 16: An ASCP graduation with Minister of Health and Director of DSO.**

# OBJECTIVE 3
## FACILITATE THE SUSTAINABLE DELIVERY OF QUALITY HEALTH SERVICES THROUGH THE INSTITUTIONALIZAION OF KEY MANAGEMENT PRACTICES AT FACILITY AND COMMUNITY LEVELS

Annual Highlights

- ✓ 98% reported client satisfaction with services received
- ✓ 93.3% ER achievement for sites experiencing no stock outs of vital products
- ✓ 81.3% sites maintaining monthly financial statements

Support for key management practices involved a combination of mentoring visits, joint supervision, focused trainings, and capacity workshops to help facility and department personnel identify management and service quality needs, develop quality improvement plans, improve data collection and reporting capacities, and increase competencies in commodity management. Results for Objective 3 were significantly varied. While selected indicators fared well, others saw performance fall from PY2, in part due to the suspension of TA and related activities that resulted from SSQH's changed scope of work. With no team in place to monitor and support financial management, CQI, and supervision, SSQH noted a substantial slide in performance. Activity summaries in this section are for the October 2015 – March 2016 period.

### CONTINUOUS QUALITY IMPROVEMENT

In line with SSQH's approach to bringing best practices and learning to enhance and scale up existing approaches and models in use within the Haitian health system, the SSQH CQI model is built off HEALTHQUAL (which collects facility performance data on the type of care that clients receive) while refining the process and expanding the type of quality indicators used. Key refinements of HEALTHQUAL's focus on HIV include the addition of FP, MNCH, WASH/infection control and prevention, and GBV clinical assistance and referral.

SSQH incorporated relevant MSPP-approved HEALTHQUAL tools and practices (with refinements detailed above) for use at facilities and oriented facility staff on refinements to the HEALTHQUAL process. SIMS, SISNU, the SSQH project data, and existing HEALTHQUAL data (for facilities already using HEALTHQUAL), complemented by client interviews and observations, help identify needed areas of quality improvement and inform quarterly action plans. Project advisors identified gaps in provider competency during sites visits, adapted existing clinical trainings, and made available updated guidelines.

By the end of PY2, all 80 facilities had continuous quality improvement (CQI) plans in place. Plans incorporated facility management, HR, and service delivery elements and identified focal points, actionable steps, and deadlines to guide plan users. In PY3, SSQH expanded content of site CQI plans in coordination with facility personnel and DDS staff. Project advisors worked with staff from 12 HIV sites to update CQI plans to incorporate actionable steps for managing LTFU. A workshop with facility staff reoriented them to LTFU algorithms and helped participants review site-level LTFU data, identify problems and solutions, set goals for the immediate future, and establish actions, timelines, and responsible persons for completion. With revised plans in place and facility staff refreshed in MSPP

protocol and project algorithms, onsite supportive supervision visits by SSQH advisors reinforced LTFU management practices, helped facility staff advance actions, and engaged CHW supervisors in involving polyvalent CHWs in HIV management. Departmental staff participated in the supervision visits and play key roles in advancing actionable items outlined in the CQI plans, in coordination with site-level quality committees.

**Figure 17: Facility repainted in Il-a-Vache region.**

Despite the above-mentioned activities and successes, SSQH was not able to document the implementation of CQI plans at many project sites (27.5% ER achievement for indicator O3.03). With first semester activities focused on ameliorating identified areas of improvement, CQI activities emphasized HIV, infection control, and waste management elements. With the change in project scope in April, SSQH could no longer monitor and support CQI activities and consequently this indicator's performance fell sharply from PY2. Similarly, the percent of site-level CQI teams that are staffed and meet regularly (indicator O3.08) could not be actively monitored and reinforced across the SSQH network, resulting in only a 29.8% ER achievement.

## FINANCIAL SYSTEMS

SSQH continued its support for financial systems and management at the facility level. Project advisors conducted site visits to review monthly financial reports, usage of financial tools, and adherence to established procedures used for tracking and documenting financial transactions. Through this process, advisors reinforced capacities of financial management staff. For the year, all 45 NGO-supported sites and 20 ZC sites maintained monthly financial reports (as of March 2016). Nonetheless, SSQH noted a slight decline in indicator performance from PY2 for the percent of sites maintaining auditable monthly financial reports (81.3% ER achievement). This is a result of SSQH not being able to conduct necessary financial management activities during the second half of the year.

## DATA MANAGEMENT

Data quality assessments (DQA) and capacity support continued at sites and departments during the reporting period. DQAs continue to highlight capacity limitations in data collecting and reporting at the facility level. Common obstacles noted during the visits include unavailability of MSPP registers and guidelines, transcription errors between registers and monthly reports, insufficient quality validation steps by CHW supervisors to review CHW monthly data, and incomplete monthly reports and *tableau de bords* (TdBs). Inconsistent use of data collection tools and confusion over how to properly complete them did not help site personnel effectively manage and use data. Furthermore, recent design changes to the MSPP monthly report form required that staff be oriented on how to use it.

SSQH responded to these problems and capacity needs through several interventions. As part of the onsite DQA process, project M&E advisors reviewed problems with site staff, discussed why the problems were present, and capacitated them to correct issues. Through an internal analysis and reflection process, SSQH identified ways to improve its own DQA tool by adding CQI elements. The tool consists of five sections that measure: the timely submission of reports; data validity (indicators, registers, and reports); data use practices; availability of tools and registers; and CQI steps (problem identification, improvement objectives, and action plan). Information gathered from use of this tool served as the foundation for tailored capacity support and actionable steps for quality improvement. These fields enable SSQH advisors and site staff to clearly map a path and timeline from problem to solution in a system of joint accountability. Persistent and/or widespread problems informed SSQH trainings/workshops for site and departmental staff. As part of the follow-up mechanisms in place, SSQH advisors call site staff to check on action progress and where possible, ask sites to email/text evidence of the actions made. SSQH advisors also monitor data quality through HMIS database reviews to see if the data reported has any outliers. DQA site visits were conducted at 22 sites during the year.

A common challenge experienced is that many sites do not have reliable or complete stocks of data collection and usage tools and support resources. Routine site visits identified TdBs and registers are often incomplete or in some cases outright missing. During the period, SSQH procured and delivered new white-board TdBs to 35 sites and helped site staff update them with correct annual targets and performance data. SSQH also procured and is currently delivering multiple data tools to sites, including MSPP “guide de remplissage”, which guides facility staff through steps for properly completing MSPP monthly reports and tools.

In support of onsite capacity building efforts, SSQH conducted a training session in coordination with MSPP/PNLS and other partners, to orient participants in how to complete MSPP registers and reports for HIV services. Fifty-nine (59) site managers, data clerks, DROs, and Departmental M&E officers, representing 26 institutions and two DDS, participated in the training. Participants learned how to use HIV monitoring tools, engaged in strategies for using data for decision-making, and gained skills in how to manage staff to correctly complete tools for data collection and reporting. They discussed problems arising in and solutions to completing registers and reports for pre-ARV, ARV, HTC, prenatal, maternity, and pediatric services.

Despite strong efforts to reinforce site data management and reporting, SSQH saw a decrease in performance for percent of sites submitting monthly reports on-time during the period (50% ER achievement, measured for the month of June 2016). This performance is due to a number of sites not submitting a monthly report to the DDS at all, which illustrates the need to reinforce data management coordination between the sites and the departments. Indeed, of the sites that did submit monthly statistical reports, 100% submitted them on-time.

**Figure 18: Installation of a rain water catchment system to feed into clean water system in Corail region.**

## INFECTION CONTROL & WASTE MANAGEMENT

Building off the infection control plan template developed in PY2 and already used at more than 30 sites, SSQH expanded the tool to incorporate waste management elements and tailored content based upon service level (disp., CSL, CAL, and HCR). During the reporting period, twenty-five (25) sites updated/developed infection control/waste management plans and received reinforcement of waste management practices and principles[10]. These plans identify actions, responsible persons, and deadlines for clarity and accountability. Once these tools were updated, SSQH advisors provided onsite supportive supervision visits to monitor use of the tools and reinforce provider capacity. During these visits, project advisors review infection prevention and waste management steps, refresh providers in knowledge of collecting, handling, and managing waste, and identify areas of weakness and outline course correction steps. SSQH conducted onsite mentoring visits to reinforce infection control/waste management practices and guidelines at sites.

## SUPERVISION

The SSQH approach to supervision is formative, in which SSQH advisors aim to empower facility and community to succeed in difficult and resource-strapped environments. Supervision is combined with on-the-job training and coaching to maximize TA support and ensure facility providers receive capacity support in various situations. SSQH coordinates with DDS staff in joint supervision activities. These supervision visits aim to both reinforce facility staff capacities as well as develop departmental staff aptitude to provide supportive supervision.

[10] Infection control/waste management plans include six categories: management of controlling waste and infection; training needs (initial and ongoing); hygienic practices of personnel; management of the physical environment; monitoring and reporting; and additional support.

A supervision team consisting of SSQH advisors and one or more DDS staff (i.e. RH service head, Program assistant for Nutrition, etc.) arrives onsite and meets with the site manager to discuss the last supervision visit, technical areas covered and the issues identified. The joint supervision team then joins facility staff to provide supportive supervision. The SSQH Supervision Checklist guides the supervision team through myriad service components, including MCH, HIV/TB, PF, laboratory, GBV, waste management, facility management, CQI, and RBF. Depending upon the expertise of the supervision team members, they provide supervision in multiple areas. Positive practices are reinforced and issues and corresponding actions are identified and recorded in the tool. This documentation is shared with the facility and informs future actions and supervision visits. During the semester, SSQH and DDS staff conducted at least one joint supervision visit at 53 sites, and at least two supervision visits at 30 sites.

## SUPPLY-CHAIN MANAGEMENT

SSQH continued its support to supply chain management at the facility level. In addition to supporting the management of essential medicines, SSQH responded to USAID's request that the project also support facility-level HIV commodity management needs, which had historically been provided by SCMS. SSQH also took on support for FP commodity reporting and support in the wake of the LMS closeout last year. Facilities submit monthly commodity consumption reports to the project and advisors help identify low inventory levels and provide follow-up support on resupplying. The accurate and timely submission of consumption reports plays a critical role in reducing stock outs at facilities and enables sites to enter additional orders of commodities when prior SCMS deliveries do not align with demand. Onsite TA builds the capacity of stock managers in commodity management. During the semester, SSQH worked onsite with several stock managers and pharmacists to clean and organize stock rooms, commodity storage, and reporting.

At the 17 HIV facilities, SSQH commodity & logistics advisors assessed capacities and developed action plans to help facilities receive, manage, and dispose of health commodities. Twenty (20) sites and two CDAI (public regional warehouse) received on the job training in the use of job aids, stock cards, forecasting methods, and consumption reporting. During the semester, no HIV site experienced stock outs in HIV or three essential opportunistic infection (OI) commodities. HIV sites also achieved a 93% timely receipt of HIV commodity consumption reports. Additionally, SSQH supported the 77 FP sites to collect commodity data, submit consumption reports, and manage stocks.

One issue experienced during the semester was the insufficient distribution of commodities due to under-estimated needs. SSQH responded in collaboration with sites receiving insufficient stocks and requested shipment of additional stock. Fortunately stock outs of drug supplies were averted.

Despite challenges with forecasting in selected sites, SSQH measured only an 11.4% stock out rate at supported sites as of March 2016 (a 93.3% ER achievement rate). SSQH had to change the tracer drugs in PY3 due to data availability, as Cotrimoxicol and folic acid/iron are no longer included in the MSPP monthly report. However these drugs were replaced with similar ones as tracers.

## GENERAL FACILITY MANAGEMENT

In support of general facility management, SSQH completed a number of light infrastructure improvements at six (6) sites. The work targeted waste management issues, repaired broken or nonfunctioning water systems, reorganized facility stockrooms and pharmacies, and improved general

facility aesthetics. SSQH technical advisors worked with facility management and Departmental representatives to identify key needs and maintenance gaps and organized rapid yet effective infrastructure improvements to render maximum quality impact. Key interventions included installing/repairing waste disposal and burn pits, rehabilitating water management structures and systems – including the new design and installation of a rain water catchment system at HCR de Corail, repairing and upgrading toilet and sanitation blocks, and reorganizing stockrooms and pharmacies for improved organization and efficient inventory management. Project advisors complemented the infrastructure work with targeted technical assistance and capacity reinforcement to site personnel in waste management/infection control, commodity and stock management, nutritional support management (i.e. reviewing national protocol in malnutrition management, and planning community nutrition activities), and refreshers on completing/using registers (i.e. vaccination).

In complement of the infrastructure work directly commissioned and executed by the project is rehabilitation work at two (2) sites in which the facilities invested their own funds to complete. SSQH project advisors collaborated with site management to identify hygiene and sanitation gaps and design improvements to be financed directly by the sites using non-project funds. Based upon project recommendations, Delmas 75 and Martissant have renovated facility toilets, washrooms, and showers; redeveloped the existing kitchen and the sanitary units for pediatric services, and constructed enclosures for waste management areas. SSQH advisors monitor the work and provide facility management guidance to ensure the work is completed satisfactorily. This level of support introduces a new element of sustainability in SSQH's work by using project resources and expertise to leverage external funds to advance project and facility objectives.

| Facility Name | Infrastructure Improvements Completed |
|---|---|
| CS Ile-a-Vache | Cleaned facility courtyard and removed garbage and waste<br>Repaired facility door and ceiling<br>Electrical fixtures repaired and light bulbs replaced<br>Rearranged facility depot and inventoried content<br>Toilet repaired and cleaned<br>Waste burn pit constructed<br>Painted facility |
| CAL de Bainet | Cleaned facility courtyard and removed garbage and waste<br>Repaired masonry and ironwork of waste management area<br>Painted facility<br>Repaired roof and light fixtures<br>Provided tools for keeping courtyard clean (rake, shovel, and wheelbarrow)<br>Rearranged facility depot |
| Disp. de Bahot | Constructed waste management pit<br>Reinforced fence around courtyard<br>Installed new screens to prevent entry of animals<br>Installed new drainage around facility courtyard to remove standing water<br>Painted facility exterior |
| CS Leon Coicou | Complete renovation of the facility's water and sanitation system<br>Installed two new toilets, sinks, and plumbing<br>Reinforced wall in clinic's urgent care room<br>Installed a new sink in the lab<br>Installed new windows and screens in the toilet block<br>Painted facility exterior |
| HCR de Corail | Installed a rain water catchment system as a feeder to the hospital's clean water system<br>Installed a new hydraulic pump<br>Complete revision of hydraulic and sanitary system (toilets, sinks, and plumbing) |

**Table 8: Infrastructure Improvements**

# OBJECTIVE 4
## STRENGTHEN DEPARTMENTAL HEALTH AUTHORITIES' CAPACITY TO MANAGE AND MONITOR SERVICE DELIVERY

Annual Highlights:

- ✓ 6 DPOs hired and placed at each of the DDS
- ✓ 15 sites for RBF pilot have updated business plans with targets and action steps

Indicators measuring Objective 4 performance did not perform as well as desired, with all four failing to achieve their ER for the year. Several supporting activities were rescheduled for the second semester while SSQH focused on hiring and orienting the DPOs, but were dropped outright once the scope changed in April 2016.

## SUPPORTING DEVELOPMENT OF DEPARTMENTAL MANAGEMENT SYSTEMS

SSQH continued its support for the Departments during PY3. The project invested in departmental budgeting and planning, awareness and utilization of data systems, and strengthening and systematizing supervision. Advancement of the RBF pilot activities continued at 15 sites while USAID finalized its mechanism for transferring RBF incentive payments to facilities and departments.

### Departmental Budgeting and Planning

In the beginning of PY3, SSQH coordinated with the DDS in preparing their workplans and budgets for the year's activities. The project asked departments to submit their individual workplans ahead of the project's annual workplan submission to USAID. DDS activities that clearly coincide with SSQH objectives and priorities were then incorporated into the project workplan, taking into account budget and other needs and considerations specific to each DDS. This helped to ensure that SSQH activities aligned with the DDS integrated plan, or plan départementale intégré (PDI), which outline the DDS's multi-year strategies and goals. In hand with this process, the project reviewed and agreed upon joint DDS budgets which the project would support. SSQH staff focused on: standardizing costs across budget items (e.g., gasoline, insurance, confirming staff are paid at least the minimum wage, etc.) and ensuring that mandated SSQH activities such as trainings, mobile clinics, and supervision visits were included.

### Departmental Program Officers

Following agreements reached in December 2015 with MSPP and USAID, SSQH created and filled the post of DPO at each of the DDS. The principle role of the DPO is to facilitate coordination and implementation of SSQH-supported and department-managed activities. As a SSQH focal point based at the DDS, the DPOs coordinate joint field supervision visits, on-the-job training and workshops, technical assistance, and partnership activities. The recruitment process was participatory with the departments, with DDS personnel part of the recruitment team and candidate selection. By June 2016, all six departments had DPOs hired. Unfortunately some of the candidates did not remain in their post due to other departmental changes (i.e. the DPO for Centre Department became the Director), and MSCP will work to fill vacancies. Nonetheless the DPOs served as critical linkages between SSQH and the DDS, as well as between Pathfinder and MCSP for SSQH transition.

DPOs worked jointly with departmental technical staff to provide formative supervision at sites, covering topics such as waste management and data reporting and use (in particular HIV, MCH, and FP). Follow-up and customized technical assistance helped to address needs identified during supervision visits. In Grand Anse, for example, the DPO focused TA on integrating ASCPs in LTFU and HIV case management. On-the-job training in community HealthQual and immunization reinforced health staff capacity, while a joint workshop with PNLT on TB and malaria benefitted 15 site coordinators and staff. Additionally, the DPOs helped with the transition to MSCP, helping to coordinate new contract signing, updating site provider data, and following up on SIMs surveys at sites.

Despite these advancements, there have been challenges in the work DPOs perform. High turnover at the departmental level creates a transitory environment, adding difficulty to the workload. During the period, three departments had turnover and not all new leadership or staff have a full appreciation for SSQH's work. Secondly, some DPOs have largely focused their support for ZC sites, while NGO sites have not received the same level of attention. While there are exceptions (the DPO for the Ouest department has worked well with NGO sites), more reinforcement for all DPOs will help ensure there is uniform support regardless of management affiliation.

**Figure 19: DCNI and SSQH advisors hold coordination meetings in Nippes.**

Data Use for Decision-Making & Supervision

As part of the project's efforts to reinforce Departmental capacity in data and performance management, SSQH coordinated quarterly performance review sessions with UEP, DDS, and institutional personnel. The overall goals of the performance review sessions are to support Departmental staff to lead a process of engaging institutions in reporting data, problem identification, and capacity reinforcement for completing monthly reporting requirements. The sessions examined site reporting rates (on time, complete, and accurate), analyzed data for quality improvement, reinforced capacities in completing monthly reports, examined relational yet problematic indicators for validation, and reinforced tools and register use. In Central Plateau, for example, performance review of the October – December 2015 data showed that while 100% of sites submitted complete monthly reports, only 68% did so on time. Participants discussed why on time reporting is a challenge and what strategies sites could employ to address them. The performance review sessions complement the follow-up onsite

supervision visits supported by Departmental personnel. SSQH supported the Departments in developing and implementing their quarterly calendars for supervision DQA visits. These calendars identify sites, activities planned (i.e. supportive supervision, distribution of tools, and collecting missing reports), dates scheduled, and focal points.

While the performance review sessions are a new and helpful process to capacitate Departmental personnel in the management of data reporting and quality at their institutions, there remain areas of needed improvement. Experience showed that performance data could be presented in more detail so as to help participants better identify challenges and use this information for follow-up site visits. For example, much of the performance data presented (i.e. timeliness, completeness, and precision of reporting) was consolidated by commune level, rather than institutional level. This clustering of information prevented participants from identify where certain problems exist. Another limiting factor in the preparation of the review sessions was SSQH's previous inability to access data from the SISNU-MSPP database. SSQH has managed its own SISNU-USAID database, but often this was incomplete, as many ZC sites would only submit their monthly reports to the DDS and not the project (per MSPP mandate). This resulted in SSQH having a different data set than the DDS and not being able to use it to help identify problems such as reporting coverage, submission dates, data quality, and completeness. Fortunately SSQH now has access to SISNU-MSPP and can provide helpful analysis to DDS staff in preparation for future quarterly review sessions. Results from future review sessions will also inform Departmental supervision calendar development.

Support for joint supervision site visits involving DDS personnel continued during PY3 and focus has been to invest in supervision as a function owned and led by the departments. Building off the capacity workshops conducted in PY2, SSQH supported the departments in developing quarterly supervision calendars in which site visits and supervision topics are identified. Project advisors, when possible, participate in the supervision visits so that Departmental staff capacities are reinforced.

## RESULTS-BASED FINANCING

USAID and MSPP finalized the funding mechanism that will enable the transfer of funds for incentive payments under the RBF scheme. Under a government-to-government mechanism, USAID will transfer RBF funds directly to GOH, thereby removing SSQH from the process of paying incentives. Instead, SSQH focuses on providing the TA necessary to facilities and department to help them achieve RBF targets and maximize incentive eligibility.

SSQH continued to support the 15 pilot sites in updating their business plans, providing refresher trainings on RBF process, and delivering TA to address identified areas requiring improvement. Each site business plan identifies indicators and corresponding targets, as well as timeline and resources for achievement. Project advisors helped the sites prepare a list of risks and needs for the sites. These lists will be important to include in future TA and other support to ensure the 15 sites can manage have the sufficient resources and structure to manage risks. The RBF pilot sites also received CQI training during semester. Next steps should include review of the site-level VRS assessment results with the sites and update business plans accordingly. SSQH TA should respond to needs and goals identified in the plans to ensure site performance and incentive eligibility increases.

Finally, SSQH continued its participation and support for the RBF Groupe Technique de Travail (GTT). SSQH advisors provided ongoing technical support to the working group for the Revised RBF Manual of Operations, which was recently finalized.

# MANAGEMENT, MONITORING, AND ADMINISTRATION

SSQH-CS supports MSPP in the improvement of the health status of the Haitian population. The project does this in close collaboration with USAID, local implementing partners, and other USG partners. PY3 saw a renewed and more collaborative partnership with the six DDS, with new investments in resources and personnel for improved coordination and stronger results.

## PROJECT MANAGEMENT

SSQH made important strides in its project management and relationship with MSPP during the first semester of PY3. Prolonged vacancies of key personnel positions during PY2 were filled with new, qualified staff and enabled SSQH to set a new tone of leadership for the project and partnerships. New staff filled the roles of COP, technical director, and a newly-created senior program manager in December and January. Necessary changes in the project's staffing structure helped improve staff management and coordination. Following a partners' conference with MSPP, USAID, and the two SSQH projects in December, SSQH made several project management changes to improve coordination and implementation with the DDS. SSQH added the post of program officer at each DDS to serve as a liaison between the project and the departments. Recruitment for these positions was a joint venture involving DDS and SSQH staff. By the June, all six posts had been filled. Finally, SSQH transferred a project vehicle to each department to assist their implementation of activities.

**Figure 20: SSQH departmental program officer and site personnel review PPS de Cinquième performance data.**

## MONITORING SYSTEMS

In February, SSQH made critical adjustments to it Performance Indicator Reference Sheet (PIRS) to sharpen performance measurements. Several indicators had their definition and/or data sources updated, while one indicator was removed. The PMP currently has 68 indicators. However, with the

change in project scope, effective April 2016, activities planned and designed to advance several indicators' progress were suspended indefinitely. The cessation of these activities, which include provider trainings and community mobilization efforts, means SSQH could not produce results to advance indicator performance. As these activities were planned over the full 12 month period, but cut short before they could all be fully realized, SSQH has decided to report "N/A" for the corresponding indicator results for the year. This decision was shared with USAID in May 2016. In total, SSQH reports "NA" for five indicators for PY3.

Register availability at a number of sites posed obstacles to reliable and complete reporting during the year. SSQH responded by coordinating with various partners to see if stocks of registers were available for sites. The project also ordered other tools and distributed them to sites during the year, as well as providing training to providers in how to properly use them.

Finally, an important shift in project data management and reporting manifested in PY3. With MSPP's decree in July 2015 that service delivery points must no longer submit monthly statistical reports to implementing partners, but should instead submit them directly to the DDS, SSQH was forced to adapt its data collection and reporting: it abandoned the USAID-managed DHIS2 for the MSPP-managed SISNU database for non-HIV service statistics. This change had several key ripple effects for the project. First, the data flow shifted from a site > project direction, to a site > department > national HMIS direction, from which SSQH downloads its results. This additional step, while beneficial in support of MSPP to manage its own data, further removed SSQH from the data quality verification process, as it no long uploaded results directly to DHIS2. This placed further burden on SSQH to ensure that data quality activities conducted at the site level resulted in data validation and assurance steps at the departmental level. Second, this change in data flow compelled SSQH to change the type of technical assistance it provides in terms of data management. While SSQH has always provided data use support to both sites and departments, data quality assessments previously focused at the site level, with DDS personnel participation. However, the data flow change mentioned above has required SSQH to now provide DQA support at both sites and the departments, as data transfer now takes place at the DDS. While TA is provided, there is no quality assurance mechanism SSQH has to ensure the needed changes are reflected in SISNU; SSQH is dependent upon the DDS to make necessary corrections.

Looking forward, this data relationship change means SSQH will need to adapt its implementation model. It was introduced at the national workshop held at Decameron in August 2016 that next year's national SSQH implementation model would include a more robust presence at the departments. A team comprising of a project officer, field service officers, and community mobilizers will coordinate project activity implementation within each department. However, missing from this model is the data management support necessary with the new data flow model. It would be prudent for SSQH to ensure a constant data management and support presence at the departmental level.

## CHALLENGES

As discussed previously, USAID decided to change SSQH's scope in March 2016 to completely remove TA support from the project and focus exclusively on service delivery contracting. Implications of this decision rippled across the program year and work plan, as many activities planned for the second semester never were implemented and many gains from the first semester in terms of DDS partnerships and service delivery quality reinforcement lost momentum and changed course. The consequence was that many expected results declined or could not be reported by the end of the period.

Another challenge faced pertains to how PEPFAR priorities have redirected HIV/TB investments, which has left certain institutions and the clients they support without clear solutions for continuing care and treatment. SSQH focused its investments in 17 sites during PY3, down from23 in PY2, in response to PEPFAR guidance on minimum annual client volume thresholds. This decision means the six sites not identified for future investment need alternative strategies for keeping their clients in care and treatment. SSQH brainstormed with partners on temporary measures to maintain care access for affected clients, such as transportation arrangements for people, medication, and laboratory specimen, but cessation in TA and other logistical challenges prevented such measures to be durable solutions. USAID will want to carefully consider how it plans to manage care access for these individuals and it moves forward with future investments.

Finally, data challenges continue to be an issue for the SSQH network. SSQH found that SISNU did not have complete data for most MCH indicators. For prenatal, postnatal, nutrition, and Vitamin A data, SSQH noted many sites did not have results posted in SISNU. To supplement the missing data, SSQH used the MSPP monthly statistical reports submitted to SSQH by NGO partners. However, vaccination data presented a unique challenge. SSQH found entire departments were missing vaccination data in SISNU. Other data that was present did not pass basic validity tests. Upon further inquiry, SSQH learned that vaccination data, which is not included in the MSPP monthly report form, is managed separately at the departmental level by DPEV. Not all vaccination data found its way into SISNU, so SSQH sent DQA teams to four departments (Centre, Ouest, Nippes, and Grand Anse) to review DPEV reports and compile vaccination results separately. The DDS authorized the compiled data tables, which were used to calculate the overall results. Unfortunately, SSQH was not able to do this for Sud and Sud-Est, despite best efforts.

## ADMINISTRATION

Following reports that a small number of ZC personnel were not able to access salary payments reliably via *Tcho Tcho* due to cash out agents not always having sufficient funds on hand, SSQH coordinated with Digicel to take action. Each month, Digicel provides SSQH a list of “mon cash” agents who have capital, which is shared with the ZC staff via SMS to let them know where they can cash out and avoid needed to do so in multiple locations for their salary. SSQH also engaged the financial officers seconded to the DDS to educate them on how *Tcho Tcho* works so they could be focal points for ZC staff having difficulties.

## ENVIRONMENTAL COMPLIANCE

Light renovation work at several SSQH facilities took place during the first semester. The work replaced aging water and sanitation infrastructure such as pipes, sinks, and toilettes/latrines. Facility courtyards were graded with improved drainage material or concrete. One facility had a rainwater catchment system installed, and two had new water pumps installed. All work designed and conducted adheres to the SSQH EMPR, and the project WASH advisor monitored and inspected the sites during the work and upon completion to ensure proper mitigation measures were in place and effectively protecting the area and visitors. Table 8 (Objective 3) presents a summary of all work completed this semester. Coaching and mentoring of facility staff on environmental mitigation, waste management, and infection control also continued during PY3.

# SUCCESS STORIES

## JULIEN JOSEPH EDNER


Julien Joseph Edner is a certified Agent de Santé Communautaire Polyvalent (ASCP) with the SSQH project. He lives in the Corail community, located in Grand Anse, and covers four sectors, Lobo dlo 2, Lotbodlo 1, Fond Fery, and Cite Beda. Corail is an area known to be particularly difficult to access, far from the capital on treacherous roads. It is in rural, remote areas such as this that the role of these community-based ASCPs is particularly crucial in making health services accessible.

At 66 years old, Julien has been involved in health services in his community for more than 10 years, and through the SSQH project, received additional training to expand his health expertise. Prior to his ASCP training, Julien specialized as a TB agent. Now, with training from SSQH, he is also able to provide services in maternal and child health, family planning, STI/HIV/AIDS prevention and follow-up, and nutrition.

Julien is particularly affected by the children he helps in his community. One of his most memorable cases was when during a home visit he saw a child with an abscess on his neck. Fearing lymphoid TB, he advised the mother to take her child to the affiliated health center. He was proud to see that after the child received the necessary medical attention, he made a full recovery. However, being an ASCP is not always easy. Julien laments, “I am so sad the kids do not love me because they see me as the person who hurt them by giving them their vaccine shot.”

**Figure 21: An ASCP describes the passion and respect he derives from working with the SSQH-CS project.**

In addition to his work as an ASCP, Julien spends time as a tailor and as a farmer. However, he is most known and respected in his community as an agent of health. This is a role he takes very seriously and is proud of, as evidenced in his quote, “I like what I am doing, I like my community, and when I commit myself to do something, I mean it.”

## HYPOLITE WILIO

Hypolite Wilio is 42 years old, and lives in the Corail commune of Grand Anse. For many years, he was involved in grassroots organizations in his community, and for the past three years has been a community health worker in five communities in Corail: Astier, Lepinee, Jacques, Beguin, Nanpos. Through the SSQH project, he received training and certification as an Agent de Santé Communautaire Polyvalent (ASCP), thus expanding his skills to provide first level services in maternal and child health, family planning, STI/HIV/AIDS and TB prevention and follow-up, and nutrition.

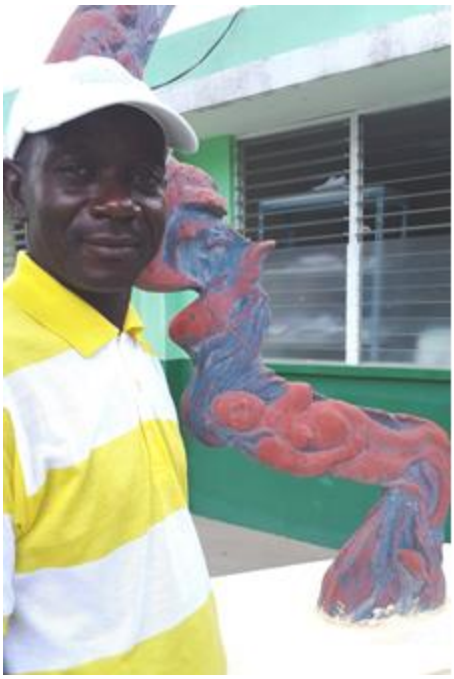

**Figure 22: Hypolite Wilio, from Grand Ans,e works in rural areas of Corail.**

Corail is a very remote community, making access to health services extremely challenging to its residents. Corail is two hours from the capital of Gand Anse and eight hours from Port-au-Prince, only accessible using very bumpy roads and dangerously steep slopes. Through the training of ASCPs, Pathfinder has significantly improved access to a multitude of health services in this remote area. As an ASCP, Hypolite visits clients at home, and will sometimes even pick up their medicine and deliver it to them.

One of the most memorable clients for Hypolite was a three-year old-girl he identified with severe malnutrition that he met during a routine home visit. Despite the fact that the child had all the classic symptoms of malnutrition, including oedema, skin and hair depigmentation, and dermatologic lesions, her grandmother, who was her primary caregiver, did not recognize the cause and only sought treatment from traditional healers. Hypolite quickly recognized the symptoms and convinced the grandmother to take the child to the affiliated health center. With improved nutrition her health improved dramatically and she is now thriving, having just celebrated her fourth birthday.

Hypolite feels very proud to be an ASCP, or “Polyvalent” as they are often referred to. He believes that without his help the three-year-old girl would have died. Now, because of his multifaceted training from SSQH and his presence in the community, she is living a happy and healthy life. Having a background of serving his community through church activities and working with other local organizations, Hypolite concluded, “I realized at the end that my status as an ASCP would give me an even greater opportunity to better serve my brothers and sisters.”

# ANNEXES

A. SSQH-CS PMP Indicator Summary Table with Annual Results
B. SSQH-CS Summary of Infrastructure Improvements